

SATISFACTION OF MORTGAGE

KNOW ALL MEN BY THESE PRESENTS, That _____

owner and holder of the Mortgage and the obligation hereinafter described, do hereby certify and declare that a certain mortgage, bearing date the 20th day of April, 1973, made and executed by Leon R. Palmer and Sally E. Palmer, husband and wife, the mortgagor therein to,

Clair A. Palmer and Virginia M. Palmer, the mortgagee therein, and recorded in the office of the Klamath County Clerk, State of Oregon, in Volume M73, Page 5110, Microfilm Records of Klamath County, Oregon, on April 30, 1973.

together with the debt thereby secured, is fully paid, satisfied, and discharged.

In construing this satisfaction of mortgage, where the context so required, singular includes the plural and all grammatical changes shall be implied to make the provisions hereof apply equally to corporation and to individuals.

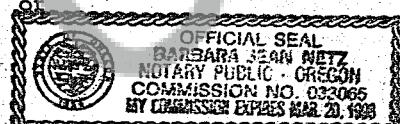
IN WITNESS WHEREOF, the undersigned has executed this instrument this day of _____, 19____; if the undersigned is a corporation it has caused its name to be signed.

James M Palmer

STATE OF OREGON, County of Multnomah) ss.

This instrument was acknowledged before me on 5-31, 1996
by JAMES M PALMER

This instrument was acknowledged before me on _____, 19____
by _____
as _____
of _____



Mortgagee: James M Palmer

Barbara Jean Netz
Notary Public of Oregon
My commission expires 3-20-98

STATE OF OREGON, }
} ss

County of Klamath }

I certify that the within instrument was received for record on the 14th day of June, 1996, at 2:52 o'clock P M, and recorded in Volume No. M96 on page 17850 or as /instrument/ No. 19907, Record of Mortgages of said County.

Witness by my hand and seal of County affixed

AFTER RECORDING RETURN TO:

Amerititle

Bernetha G. Letsch, Co Clerk

NAME

TITLE

Sophie G. Letsch Deputy

FEE:\$10.00

**OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS**

ENT
LINK
167083
LD. TAG NO.
256
Local File Number

**OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS**

95-012014

State File Number

1. DECEDENT'S First Name Nellie	Middle Name M.	Last Name ALVAREZ	2. SEX Female	3. DATE OF DEATH (Month, Day, Year) June 2, 1995
4. SOCIAL SECURITY NUMBER 581-28-8383	5a. AGE-Last Birthday 84	5b. Under 1 Year Mos. Days Hours 0	5c. Under 1 Day Hours 0	6. BIRTHPLACE (City and State or Foreign Guatamalu, Mexico

7. WAS DECEDENT EVER IN U.S. ARMED FORCES <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	8. HOSPITAL <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient	9. DOA <input type="checkbox"/> Death <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)	10. PLACE OF DEATH (Check only one) <input type="checkbox"/> Other <input checked="" type="checkbox"/> Klamath Falls	11. DATE OF BIRTH (Month, Day, Year) December 7, 1910
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12. FACILITY NAME (If not institution, give street and number) Merle West Medical Center	13. CITY, TOWN OR LOCATION Klamath Falls	14. COUNTY OF DEATH Klamath
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15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life) <i>Do not use retired</i>	16b. KIND OF BUSINESS/INDUSTRY Laundry Industry	17. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Widowed	18. SPOUSE (If married, Widowed) Severino Pancho Alvarez
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13a. RESIDENCE STATE Oregon	13b. COUNTY Klamath	13c. CITY, TOWN OR LOCATION Klamath Falls	13d. STREET AND NUMBER 4537 Winter Avenue
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13a. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13b. ZIP CODE 97603	14. WAS DECEDENT OF HISPANIC ORIGIN? Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc. Mexican	15. RACE American Indian, Black, White, etc. (Specify) Hispanic	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)
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17. FATHER'S NAME / firm Carlos Morales	18. MOTHER'S NAME / firm Pomposa Torres	19. INFORMANT NAME AND RELATIONSHIP TO DECEDENT Teresa Herrera Daughter
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20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, cemetery, or other place) Mt. Calvary Cemetery	20c. LOCATION - City or Town, State Klamath Falls, Oregon
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21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>James O. Riggs</i>	21b. LICENSE NUMBER (OF PERSON) CO-3572	22. NAME, ADDRESS AND ZIP OF FACILITY O'Hair's Funeral Chapel
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23. DATE FILED (Month, Day, Year) JUN 05 1995	24. REGISTRAR'S SIGNATURE <i>Ellen Johnson</i>	25. WAS GIFT MADE? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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26. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	27. TIME OF DEATH 8:50 A.M.	28. WAS MEDICAL EXAMINER NOTIFIED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. <i>(Signature)</i>	30. DATE SIGNED (Month, Day, Year) 6/2/95	31. TIME OF DEATH
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30. DATE SIGNED (Month, Day, Year) 6/2/95	31. DATE PRONOUNCED DEAD (Month, Day, Year) 6/2/95
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32. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIED MEDICAL EXAMINER (Type or Print) Randal A. Machado M.D. 1905 Main Street Klamath Falls, Oregon 97601	33. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
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34. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c)) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.	35. DATE SIGNED (Month, Day, Year)
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Part (a) <input checked="" type="checkbox"/> Under natural cause <input type="checkbox"/> Kelt M70 Cardiol Infarct	36. Interval between onset and death 1 month
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Part (b) <input type="checkbox"/> Cancer <input type="checkbox"/> Injury Disease	37. Interval between onset and death 20 years
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Part (c) <input type="checkbox"/> Infection	38. Interval between onset and death years
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39. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I	40. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	41. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending <input type="checkbox"/> Death <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Legal <input type="checkbox"/> Homicide <input type="checkbox"/> Intervention	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY	41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	41d. DESCRIBE HOW INJURY OCCURRED
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41e. PLACE OF INJURY - Atmosphere, street, factory, office, building name (Specify)	41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
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42. DATE ISSUED JUN 10 1995	43. IF YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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44. RESERVED FOR REGISTRAR'S USE	45. I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE OR THE VITAL RECORD FACTS ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON HEALTH DIVISION.
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46. DATE ISSUED JUN 10 1995	47. EDWARD J. JOHNSON II STATE REGISTRAR
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48. FILED FOR RECORD AT REQUEST OF of June A.D. 19 96 at 2:52 o'clock P M., and duly recorded in Vol. 17851 on Page 1 .	49. the 14th day of June M96
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50. FEE \$10.00	51. RETURN: Marvin Dunster
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52. 704 Miles Ave	53. Billings MT 59101
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54. Bernetha G. Lisch, County Clerk	55. Leanne M. Hestey
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