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# 162595  
LOCAL TAG NO.

OREGON DEPARTMENT OF HUMAN RESOURCES  
HEALTH DIVISION  
CENTER FOR HEALTH STATISTICS

Page 27892

Local File Number

107390716

CERTIFICATE OF DEATH

136

State File Number

DECEDENT

PARENTS

REGISTRAR

WITNESS

CERTIFIED

CONDITIONS

CAUSE OF

DEATH

15

16

17

1. DECEDENT'S NAME <b>Leo Paul SHAFER</b>		2. SEX <b>Male</b>	3. DATE OF DEATH (Month, Day, Year) <b>June 14, 1995</b>
4. SOCIAL SECURITY NUMBER <b>479-22-1991</b>		5. AGE (Month, Day, Year) <b>71</b>	6. PLACE OF BIRTH (Month, Day, Year) <b>December 26, 1923</b>
7. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Other <input checked="" type="checkbox"/> Mobile Park	
9. FACILITY NAME (If not institution, give street and number) <b>201 Fern Valley Rd. # 822</b>		10. CITY, TOWN, OR LOCATION OF DEATH <b>Phoenix</b>	
11. DECEDENT'S USUAL OCCUPATION <b>Maintenance</b>		12. SPouse (If Married, Widowed) <b>Alice Shaffer</b>	
13. RESIDENCE - STATE <b>Oregon</b>		14. STREET AND NUMBER <b>1833 Hawthorn St.</b>	
15. COUNTY <b>Klamath</b>		16. CITY, TOWN OR LOCATION <b>Klamath Falls</b>	
17. FATHER - NAME first middle last <b>Daniel Leo Shaffer</b>		18. MOTHER - NAME first middle last <b>Ruby Hickman</b>	
19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Eagle Point National Cemetery</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Michael D. Emerson</i>		22. LICENSE NUMBER (If Licensee) <b>1411</b>	
23. DATE FILED (Month, Day, Year) <b>JUN 20 1995</b>		24. REGISTRAR'S SIGNATURE <i>Selin Colvard</i>	
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A		26. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A	
27. TIME OF DEATH <b>10:30 AM</b>			
28. TO THE BEST OF MY KNOWLEDGE, WHICH OCCURRED AT THE TIME, DATE, PLACE AND DUE TO THE CAUSE(S) AND MANNER STATED. <i>[Signature]</i>			
29. DATE SIGNED (Month, Day, Year) <b>6/20/95</b>			
30. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) <b>Bruce E. VanZee M.D. 555 Black Oak Dr. Medford Oregon 97504</b>			
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
32. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR PART 1 AND 2) Do not enter mode of dying, e.g. Car crash or Respiratory Arrest			
PART 1 a. <b>Multiple Myeloma</b>			
b. DUE TO, OR AS A CONSEQUENCE OF:			
c. DUE TO, OR AS A CONSEQUENCE OF:			
PART 2 OTHER SIGNIFICANT CONDITIONS: <b>Chronic Renal Failure, Diabetes</b>			
33. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
34. Did alcohol use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
35. Did drug use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
36. Did the death result from a fall? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
37. Did the death result from a fire? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
38. Did the death result from a motor vehicle accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
39. Did the death result from a drowning? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention			
41. DATE OF INJURY (Month, Day, Year)			
42. TIME OF INJURY			
43. PLACE OF INJURY - At home, business, school, factory, office, building, etc. (Specify)			
44. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

ORIGINAL VITAL STATISTICS COPY

48-2 Rev 11-88

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE JACKSON COUNTY REGISTRAR.

JUN 20 1995

DATE ISSUED:

*Henry Collins Jr.*  
HENRY COLLINS, JR.  
COUNTY REGISTRAR  
JACKSON COUNTY, OREGON



After recording return to:  
Alice C. Shaffer  
1833 Hawthorne St.  
Klamath Falls, OR 97601

STATE OF OREGON, ss.  
County of Klamath

Filed for record at request of:

Amerititle  
on this 6th day of September A.D., 19 96  
at 11:36 o'clock A M. and duly recorded  
in Vol. M96 of Deeds Page 27892  
Bernetha G. Letsch County Clerk,  
By *Cherry L. Lusk*  
Deputy.  
Fee, \$10.00