25172

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

MT 39222-MS Vol M96 Page 29337

194720 I.D. TAG NO.
39 Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

96-02393 State File Number

'96 SEP 17 A11:43

1. DECEDENT'S NAME: First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)	
Ima	Jean	ROBINSON	Female	January 25, 1996	
4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (Years)	5b. Under 1 Year: Mos. / Days	5c. Under 1 Day: Hours / Mins	6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Month, Day, Year)
429-86-4304	55			Malvern, Arkansas	October 10, 1940

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No

8a. PLACE OF DEATH (Check only one): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA | OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Merle West Medical Center	Klamath Falls	Klamath

10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	12. SPOUSE (If Married, Widowed)
Certified Nurses Assistant	Health Care	Divorced	- - -

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Oregon	Klamath	Klamath Falls	3007 Butte

13e. INSIDE CITY LIMITS?	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE - American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed)	
☒ Yes ☐ No	97601	☒ No ☐ Yes, Specify:	White	Elementary/Secondary (0-12): 8	College (1-4 or 5+):

17. FATHER - NAME first middle last	18. MOTHER - NAME first middle maiden	19. INFORMANT - NAME and relationship to deceased
Andrew - Jackson	- - Walton	Rick Robinson - Son

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - City or Town, State
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Eternal Hills Crematory	Klamath Falls, Oregon

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (Of Licensee)	22. NAME, ADDRESS AND ZIP OF FACILITY
Dale Ahlen	3588	Eternal Hills Funeral Home 4711 Highway 39 Klamath Falls, Oregon 97603

23. DATE FILED (Month, Day, Year): JAN 30 1996

24. REGISTRAR'S SIGNATURE: Evelyn Simpson

25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☒ Yes ☐ No ☐ N/A

26. WAS GIFT MADE? ☐ YES ☒ NO ☐ N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 2:55 p. M

28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes ☒ No

29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature): Kenneth K. Magee M.D.

30. DATE SIGNED (Month, Day, Year): 1-29-96

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH M

31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M

32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature)

33. DATE SIGNED (Month, Day, Year) COUNTY

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Kenneth K. Magee M.D. 1900 Main Street Klamath Falls, Oregon 97601

35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

38. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE (a), (b), AND (c).) Do not enter modes of dying, e.g. Cardiac or Respiratory Arrest.

PART I
(a) Ventricular fibrillation — Interval between onset and death: Minutes
DUE TO, OR AS A CONSEQUENCE OF:
(b) Arteriosclerotic Heart Disease — Interval between onset and death: Year
DUE TO, OR AS A CONSEQUENCE OF:
(c) — Interval between onset and death:

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.
Diabetes Mellitus type II

37. Did tobacco use contribute to the death?	36. AUTOPSY	39. If YES were findings considered in determining cause of death?
☐ Yes ☐ Probably ☐ No ☒ Unknown	☐ Yes ☒ No	☐ Yes ☐ No ☐ N/A

40. MANNER OF DEATH	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY	41c. INJURY AT WORK?	41d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Other ☐ Pending investigation ☐ Undetermined Manner ☐ Legal Intervention		M	☐ Yes ☒ No	

41e. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)

41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

RESERVED FOR REGISTRAR'S USE

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.

AUG 30 1996
DATE ISSUED

EDWARD J JOHNSON II
STATE REGISTRAR

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Amerititle the 17th day of September A.D., 19 96 at 11:43 o'clock A. M., and duly recorded in Vol. M96, of Deeds on Page 29337.

Bernetha G. Letsch County Clerk
By Kathleen Bond

FEE $10.00