

CERTIFICATE OF VITAL RECORD

MTC 41769-MS
OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS 136-
CERTIFICATE OF DEATH

079680
I.D. TAG NO.
105
Local File Number

State File Number

97 JUL -3 AM 1:52

1. DECEDENT'S NAME First: <u>Berta</u> Middle: <u>Acevado</u> Last: <u>VANCE</u>			2. SEX <u>Female</u>	3. DATE OF DEATH (Month, Day, Year) <u>February 24, 1993</u>
4. SOCIAL SECURITY NUMBER <u>566-46-5567</u>		5a. AGE Last Birthday (Years) <u>80</u>	5b. Under 1 Year Mos. Days Hours Mins	5c. Under 1 Day
6. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. BIRTHPLACE (City and State or Foreign Country) <u>Panama Canal Zone</u>		
7. DATE OF BIRTH (Month, Day, Year) <u>August 15, 1912</u>		9. PLACE OF DEATH (Check only one) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)		
10. FACILITY NAME (If not institution, give street and number) <u>Plum Ridge Care Center</u>		11. CITY, TOWN, OR LOCATION OF DEATH <u>Klamath Falls</u>		12. COUNTY OF DEATH <u>Klamath</u>
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not list retired) <u>Secretary</u>		10b. KIND OF BUSINESS/INDUSTRY <u>Office Administration</u>		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) <u>Married</u>
12. SPOUSE (If Married, Widowed, Divorced (Specify)) <u>Robert Vance</u>		13a. RESIDENCE - STATE <u>Oregon</u>		
13b. CITY, TOWN OR LOCATION <u>Klamath</u>		13c. CITY, TOWN OR LOCATION <u>Chiloquin</u>		13d. STREET AND NUMBER <u>P.O. Box 643</u>
13e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13f. ZIP CODE <u>97624</u>		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
15. RACE <u>White</u>		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>4</u>		
17. FATHER - NAME first middle last <u>Ramone - Acevado</u>		18. MOTHER - NAME first middle maiden <u>- - -</u>		19. INFORMANT - NAME and relationship to decedent <u>Robert Vance - Spouse</u>
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, crematory, or other place) <u>Eternal Hills Memorial Gardens</u>		20c. LOCATION - City or Town, State <u>Klamath Falls</u>
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <u>Charles Barcus</u>		21b. LICENSE NUMBER (Of Licensee) <u>93-49-1363</u>		22. NAME, ADDRESS AND ZIP OF FACILITY <u>Eternal Hills Funeral Home 4711 Hwy. 39, Klamath Falls, OR. 97603</u>
23. DATE FILED (Month, Day, Year) <u>MAR 0 2 1993</u>		24. REGISTRAR'S SIGNATURE <u>Charles Robinson</u>		
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A		26. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A		
27. TIME OF DEATH <u>9:30 P. M.</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. <u>Terence A. Degan M.D.</u>		30. DATE SIGNED (Month, Day, Year) <u>2-26-93</u>		
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) <u>Terence A. Degan M.D. 905 Main Street #309, Klamath Falls, Oregon 97601</u>		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)		34. COUNTY		
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)				
36. 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.)		Interval between onset and death		
PART I (a) <u>Chronic Renal Failure</u>		<u>years</u>		
DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death		
(b) <u>Artherosclerotic peripheral vascular disease</u>		<u>years</u>		
DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death		
(c)				
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. <u>Multi-Infarct dementia</u>		37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
39. If YES were findings considered in determining cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		41a. DATE OF INJURY (Month, Day, Year)		41b. TIME OF INJURY M <input type="checkbox"/> Yes <input type="checkbox"/> No
41c. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		41d. DESCRIBE HOW INJURY OCCURRED		
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)		

THIS IS A TRUE AND EXACT REPRODUCTION OF THE ORIGINAL VITAL STATISTICS COPY REGISTERED AT THE OFFICE OF THE KLAMATH COUNTY REGISTRAR.

DATE ISSUED: MAR 0 2 1993

Charles Barcus
CHARLENE BARCUS
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON



STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Amerititle the 3rd day of July A.D., 19 97 at 11:52 o'clock A. M., and duly recorded in Vol. M97 of Deeds on Page 20829.

FEE \$10.00

Return: Robert M. Vance
63579 Dickens Ct.
Bend, Or. 97701

By Berntha G. Letsch, County Clerk
Kathleen Ross