

CERTIFICATION OF VITAL RECORD

PERMANENT
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257572

ID TAG NO.

525

Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES

HEALTH DIVISION

CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

State File Number

1. DECEDENT'S - First Name Linda		2. SEX Female		3. DATE OF DEATH (Month, Day, Year) October 12, 1997	
4. SOCIAL SECURITY NUMBER 541-50-5263		5. AGE Last Birthday (Years) 55		6. PLACE OF BIRTH (City and State or Foreign Country) Ellensburg, WA	
7. DATE OF BIRTH (Month, Day, Year) March 24, 1942		8. PLACE OF DEATH (Check only one) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
9. FACILITY NAME (If not transcribed, give street and number) Marle West Medical Center		10. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls		11. COUNTY OF DEATH Klamath	
12. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of lifetime. Do not use retired) Nurse's Assistant		13. KIND OF BUSINESS/INDUSTRY Nursing Home		14. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married	
15. RESIDENCE - STATE Oregon		16. COUNTY Klamath		17. STREET AND NUMBER 6323 Dennis Drive	
18. INSIDE CITY (Is it?) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		19. ZIP CODE 97603		20. WAS DECEDENT OF HISPANIC ORIGIN (Specify: Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
21. RACE White		22. DECEDENT'S EDUCATION (Specify highest grade completed) 12		23. FATHER - Name first middle last Daie Grayden Ackland	
24. MOTHER - Name first middle maiden Betty Jane Bates		25. INFORMANT - Name and relationship to decedent Eldon Settle / Husband		26. LOCATION - City or Town, State Bonanza, Oregon	
27. 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)		28. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Bonanza Memorial Park		29. NAME, ADDRESS AND ZIP OF FACILITY Ward's Klamath Funeral Home, Inc. 1945 Main / Klamath Falls, OR 97601	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i>		31. LICENSE NUMBER (If Licensee) 1441		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
33. DATE FILED (Month, Day, Year) OCT 16 1997		34. DO HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A			
35. WAS GIFT MADE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> N/A					
TO BE COMPLETED BY CERTIFYING PHYSICIAN					
37. TIME OF DEATH 1600		38. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
39. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature) <i>[Signature]</i>					
40. DATE SIGNED (Month, Day, Year) 10/15/97					
41. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Lowell D. Smith, MD / 2610 Uhrmann Road / Klamath Falls, OR 97601					
42. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)					
43. 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.					
I (a) Renal failure		Interval between onset and death 3 months			
DUE TO, OR AS A CONSEQUENCE OF:					
II (b) Multiple myeloma		Interval between onset and death 1 year			
DUE TO, OR AS A CONSEQUENCE OF:					
III (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I					
44. 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"/> Homicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Other		45. DATE OF INJURY (Month, Day, Year)		46. TIME OF INJURY	
47. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		48. LOCATION (Street and Number or Rural Route Number, City or Town, State)		49. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
50. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		51. If YES, was findings consistent with cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
RESERVED FOR REGISTRAR'S USE					

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DATE ISSUED: **OCT 16 1997**

Marlene Blevins
MARLENE BLEVINS
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

STATE OF OREGON: COUNTY OF KLAMATH : ss.

Filed for record at request of _____
of _____ June _____ A.D., 19 98 at 3:33 o'clock P M., and duly recorded in Vol. M98
of _____ Deeds _____ on Page 21439

FEE \$10.00

Bernetha G. Letsch, County Clerk
By *Kathleen Ross*