

CERTIFICATION OF VITAL RECORD

200 MAY 12 PM 1:27

Vol. MOO Page 17353

PERMANENT
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I.D. TAG NO.
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OREGON DEPARTMENT OF HUMAN RESOURCES HEALTH DIVISION CENTER FOR HEALTH STATISTICS CERTIFICATE OF DEATH

136-

Local File Number

State File Number

DECEDENT

1

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3

4

5

6

PARENTS

DISPOSITION

7

8

9

REGISTRAR

10

11

CERTIFIER

12

13

14

CONDITIONS
IF ANY
WHICH GAVE
RISE TO
IMMEDIATE
CAUSE
STATING THE

15

16

17

CAUSE OF
DEATH

15

16

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| | | | | | |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME Leonard - Whittaker, Jr | | | 2. SEX Male | 3. DATE OF DEATH (Month, Day, Year) May 10, 2000 | |
| 4. SOCIAL SECURITY NUMBER 387-34-6323 | 5a. AGE-Last Birthday (Years) 63 | 5b. Under 1 Year Mo. Days Mo. Days | 5c. Under 1 Day Hours Mins. Hours Mins. | 6. BIRTHPLACE (City and State or Foreign Country) Goodman, Wisconsin | 7. DATE OF BIRTH (Month, Day, Year) April 30, 1937 |
| 8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 9a. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) | | |
| 9b. FACILITY NAME (If not institution, give street and number) Merle West Medical Center | | | 9c. CITY, TOWN, OR LOCATION OF DEATH Klamath Falls | | 9d. COUNTY OF DEATH Oregon |
| 10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Chef | | 10b. KIND OF BUSINESS/INDUSTRY Food Service | | 11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married | |
| 12. SPOUSE (If Married, Widowed, Divorced) (Specify) Robbie Lee | | 13a. RESIDENCE - STATE Oregon | | 13b. COUNTY Klamath | |
| 13c. CITY, TOWN OR LOCATION Klamath Falls | | 13d. STREET AND NUMBER 2211 Reclamation Avenue | | 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes, specify Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | |
| 15. RACE American Indian, Black, White, etc. (Specify) White | | 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 17. FATHER - NAME first middle last Leonard - Whittaker | |
| 18. MOTHER - NAME first middle maiden Bessie - Allen | | 19. INFORMANT - NAME and relationship to deceased Robbie Lee Whittaker, wife | | 20a. METHOD OF DISPOSITION <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State | |
| 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hills Cemetery | | 20c. LOCATION - City or Town, State Oakland, OR 97462 | | 21a. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>[Signature]</i> | |
| 21b. OREGON LICENSE NO. (Of Licensee) FS-0124 | | 22. NAME, ADDRESS AND ZIP OF FACILITY Davenport's Chapel of the Good Shepherd, 6420 So. 6th St., Klamath Falls, Oregon 97603-7194 | | 23. DATE FILED (Month, Day, Year) MAY 12 2000 | |
| 24. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | RESERVED FOR REGISTRAR'S USE | | | |
| TO BE COMPLETED BY CERTIFYING PHYSICIAN | | | | | |
| 27. TIME OF DEATH 1433 P.M. | | 28. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 29. 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) <i>[Signature]</i> | |
| 30. DATE SIGNED (Month, Day, Year) May 11, 2000 | | 31. DATE OF DEATH M | | 32. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M | |
| 33. DATE SIGNED (Month, Day, Year) COUNTY | | | | | |
| 34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) David Panossian, MD, 2628 Campus Drive, Klamath Falls, Oregon 97601 | | | | | |
| 35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) | | | | | |
| 36. PART I (a) Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. | | | | | |
| 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 checked="" type="checkbox"/> N/A | |
| 40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Other <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Legal Intervention | | 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) | | RESERVED FOR REGISTRAR'S USE | | | |

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

MAY 12 2000

DATE ISSUED:

THIS COPY NOT VALID WITHOUT INTAGLIO STATE SEAL AND BORDER.

Evelyn Simonson
EVELYN SIMONSON
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

09/ Karen Sugate

17354

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State of Oregon, County of Klamath
Recorded 05/12/00, at 1:27 p.m.
In Vol. M00 Page 17353
Linda Smith,
County Clerk Fee\$ 26⁰⁰