2009-012065
Klamath County, Oregon

00072392200900120650060069

09/09/2009 03:03:22 PM Fee: $46.00

THIS SPACE I

After recording return to:
Allyssa A. Decker
4608 Sturdivant Avenue
Klamath Falls, OR 97603

Until a change is requested all tax statements shall be sent to the following address:
Allyssa A. Decker
4608 Sturdivant Avenue
Klamath Falls, OR 97603

File No.: 7021-1449916 (ALF)
Date: July 29, 2009

STATUTORY WARRANTY DEED

Kenneth Nicholson, James A Harris and William Pratt, Trustees of the Katherine Nicholson Trust created through the the Judith Nicholson Living Trust dated March 28, 1997, Grantor, conveys and warrants to **Allyssa A. Decker** , Grantee, the following described real property free of liens and encumbrances, except as specifically set forth herein:

LEGAL DESCRIPTION: Real property in the County of Klamath, State of Oregon, described as follows:

LOT 2, BLOCK 7, TRACT NO. 1025, WINCHESTER, ACCORDING TO THE OFFICIAL PLAT THEREOF ON FILE IN THE OFFICE OF THE CLERK OF KLAMATH COUNTY, OREGON.

Subject to:

1. Covenants, conditions, restrictions and/or easements, if any, affecting title, which may appear in the public record, including those shown on any recorded plat or survey.

The true consideration for this conveyance is **$120,000.00**. (Here comply with requirements of ORS 93.030)

F46

BEFORE SIGNING OR ACCEPTING THIS INSTRUMENT, THE PERSON TRANSFERRING FEE TITLE SHOULD INQUIRE ABOUT THE PERSON'S RIGHTS, IF ANY, UNDER ORS 195.300, 195.301 AND 195.305 TO 195-336 AND SECTIONS 5 TO 11, OF CHAPTER 424, OREGON LAWS 2007. THIS INSTRUMENT DOES NOT ALLOW USE OF THE PROPERTY DESCRIBED IN THIS INSTRUMENT IN VIOLATION OF APPLICABLE LAND USE LAWS AND REGULATIONS. BEFORE SIGNING OR ACCEPTING THIS INSTRUMENT, THE PERSON ACQUIRING FEE TITLE TO THE PROPERTY SHOULD CHECK WITH THE APPROPRIATE CITY OR COUNTY PLANNING DEPARTMENT TO VERIFY THAT THE UNIT OF LAND BEING TRANSFERRED IS A LAWFULLY ESTABLISHED LOT OR PARCEL, AS DEFINED IN ORS 92.010 OR 215.010, TO VERIFY THE APPROVED USES OF THE LOT OR PARCEL, TO DETERMINE ANY LIMITS ON LAWSUITS AGAINST FARMING OR FOREST PRACTICES AS DEFINED IN ORS 30.930 AND TO INQUIRE ABOUT THE RIGHTS OF NEIGHBORING PROPERTY OWNERS, IF ANY, UNDER ORS 195.300, 195.301 AND 195.305 TO 195-336 AND SECTIONS 5 TO 11, OF CHAPTER 424, OREGON LAWS 2007.

Dated this 8th day of September, 2009.

Kenneth Nicholson, James A Harris and William Pratt, Trustees of the Katherine Nicholson Trust created through the the Judith Nicholson Living Trust dated March 28, 1997

James A Harris, Trustee

James A. Harris, Trustee

James A Harris, POA

Kenneth Nicholson, Trustee, By James A Harris as his attorney in fact

James A. Harris, POA

William Pratt, Trustee, By James A Harris as his attorney in fact

City Washington
~~STATE~~ OF ~~Oregon~~)
District of Columbia)ss.
~~County of Klamath~~)

This instrument was acknowledged before me on this 8th day of September, 2009 by ~~as of Kenneth Nicholson~~, James A Harris and William Pratt, Trustees of the Katherine Nicholson Trust created through the the Judith Nicholson Living Trust dated March 28, 1997, on behalf of the .

, individually and as attorney-in-fact for Kenneth Nicholson and

Notary Public for Oregon
My commission expires:

JUDY L. RAZE
Notary Public District of Columbia
My Commission Expires May 14, 2013

GOVERNMENT OF THE DISTRICT OF COLUMBIA — DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF DEATH

File Date: 2002 MAY 21 AM 11:41

File Number 108- 020002481

ENTRIES SHOULD BE TYPEWRITTEN ONLY USE BLACK RIBBON.

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last)	2. SEX	3a. DATE OF DEATH (Month, Day, Year)	3b. HOUR OF DEATH
Judith Nicholson	Female	May 14, 2002	7:00 P.M.

4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (Years)	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 24 HOURS: Hours / Minutes	6. DATE OF BIRTH (Month, Day, Year)	7. BIRTHPLACE (City and State or Foreign Country)
530-32-8671	70			OCTOBER 19, 1931	NEW YORK, NEW YORK

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or no) NO

9a. PLACE OF DEATH (Check only one, see instructions on other side)
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☒ Other (Specify) HOSPICE

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. CITIZEN OF WHAT COUNTRY
Hospice of Washington	WASHINGTON, D. C.	U.S.A.

10. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY / 12c. MANUFACTURER ☐ WHOLESALER ☐ RETAILER ☐
WIDOWED		CONSULTANT	HUMAN RESOURCES

SEE INSTRUCTIONS ON OTHER SIDE

13a. RESIDENCE – STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
D.C.		WASHINGTON, D.C.	2201 L STREET N.W. #906

13e. INSIDE CITY LIMITS? (Yes or no)	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) Elementary/Secondary (0-12) / College (1-4 or 5+)
YES	20037	☒ No ☐ Yes Specify:	WHITE	5+

PARENTS

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
MORRIS KISHNER	GERTRUDE KAYE

INFORMANT

19a. INFORMANT'S NAME	19b. RELATIONSHIP TO DECEDENT	19c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip C
KENNETH NICHOLSON	SON	2201 L STREET N.W. #906 WASHINGTON, D.C. 20037

DISPOSITION

20a. METHOD OF DISPOSITION	20b. DATE OF DISPOSITION	20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20d. LOCATION City or Town
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)_____	5/20/02	MOUNT COMFORT CEMETERY	ALEXANDRIA, VA.

21a. SIGNATURE OF FUNERAL DIRECTOR	21b. LICENSE NUMBER (of Licensee)	22. NAME AND ADDRESS OF FACILITY
[signature]	975	JOSEPH GAWLER'S SONS, INC. 5130 WISC. AV. NW., WASHINGTON, DC. 200

23a. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) If Yes, Type Med Ex Name	23b. DATE	24. IF DECEDENT WAS MARRIED WOMAN, ENTER MAIDEN NAME (First, Middle, Last)
NO		JUDITH KISHNER

CAUSE OF DEATH

25. **PART I.** Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

SEE INSTRUCTIONS ON OTHER SIDE

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Metastatic Breast Cancer	
	DUE TO (OR AS A CONSEQUENCE OF).	
Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**	B.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	C.	
	DUE TO (OR AS A CONSEQUENCE OF).	
	D.	

PART II: **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

26a. WAS AN AUTOPSY PERFORMED? (Yes or no)	26b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? (Yes or no)	28d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

28e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town State)

CERTIFIER

29. I certify that (I)(this hospital) attended the deceased from May 1, 2002 20__ to May 14 20 02 that (I)(we) la saw the deceased alive on May 14, 2002 and that death occurred from the causes and on the date and hour stated above.

30a. SIGNATURE	ATTENDING PHYS ☐	MEDICAL DIRECTOR ☒	STAFF PHYS. ☐	30b. DATE SIGNED
[signature]				May 15, 2002

30c. PHYSICIAN'S NAME (Type)	30d. ADDRESS
Matthew Kestenbaum, M.D.	3720 Upton Street, NW Washington, DC 20016

DOH 159
REV. 3/01

31. WAS DE... PREGN... PAST 12... ☐ YES

Authority For Cremation Granted By:

Date

I CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL CERTIFICATE FILED WITH THE VITAL RECORDS DIVISION, DEPARTMENT OF HEALTH, DISTRICT OF COLUMBIA.

WARNING: IT IS UNLAWFUL TO MAKE COPIES OF THIS DOCUMENT AND PRESENT THEM AS AN ORIGINAL CERTIFICATE COPY OR COPY OF A VITAL RECORD.

MAY 21, 2002
DATE ISSUED

Carl W. Wilson
CARL W. WILSON, REGISTRAR

VALID ONLY WITH IMPRESSED SEAL

DATE ISSUED: OCT 11 2005

I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE COPY OF A RECORD ON FILE IN THE DIVISION OF VITAL RECORDS

Geneva G. Sparks

STATE REGISTRAR OF VITAL RECORDS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#3,26 perPHYG813 11713/02 EW

Certificate of Death

Reg. No. 2002 35059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Sandra Hope Pratt	October 8, 2002	10:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
552-38-7623	1 M 2 F	70 Yrs.			Oct 13, 1931	CA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Rockville	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14401 Briarwood Terr	20853	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Research Assistant	Westat Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Morris Abraham	Eleanor Lieberman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William F. Pratt/Husband	14401 Briarwood Terr, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Chesapeake Crematory	Oct 14 2002	Beltsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypoxemia — Due to (or as a consequence of):

c. Metastatic carcinoma of the lung — Due to (or as a consequence of):

d. —

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Depression

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D34472	10/8/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Lynne Diggs MD, 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2002	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

CERTIFICATION OF VITAL RECORD

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS 136-

CERTIFICATE OF DEATH

537461
I.D. TAG NO.

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

1. Legal Name (Include AKAs, if any) — First: Kathy; Middle: Ann; Last: Evans; Suffix:
2. Death Date (MON DD YYYY): October 3,2008
3. Sex (M/F): F
4a. Age – Last Birthday: 52
4b. Under 1 Year — Months / Days
4c. Under 1 Day — Hours / Minutes
5. Social Security Number: 530-56-9997
6. County of Death: Klamath
7. Birthdate (MON DD YYYY): November 26,1955
8a. Birthplace (City/Town, or County): Berkley
8b. (State or Foreign Country): Califonia
9. Decedent's Education: Some college credit-no degree
10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.): No
11. Decedent's Race(s): White
12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No
13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8): 4608 Sturdivant Ave.
14. City/Town: Klamath Falls
15. Residence County: Klamath
16. State or Foreign Country: Oregon
17. Zip Code + 4: 97603-
18. Inside City Limits? ☐ Yes ☒ No ☐ Unknown
19. Marital Status at Time of Death: Widowed
20. Spouse's Name (if married or widowed, give name prior to first marriage.): Richard Evans
21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED."): School Teacher
22. Kind of Business/Industry (DO NOT USE COMPANY NAME.): Education
23. Father's Name (First, Middle, Last, Suffix):
24. Mother's Name Prior to First Marriage (First, Middle, Last):
25. Informant's Name: Donald Hughes
26. Telephone Number: 541-892-8167
27. Relation to Decedent: companion
28. Mailing Address (Number & Street, City/Town, State, Zip + 4): 4608 Sturdivant Klamath Falls, Oregon 97603
29. Place of Death: Hospital-In patient
30. Facility Name: Skylakes Medical Center
31. Location of Death (Give address.): 2865 Daggett
32. City/Town or Location of Death: Klamath Falls
33. State: Oregon
34. Zip Code + 4: 97601-1106
35. Method of Disposition: Cremation
36. Place of Disposition (Name of cemetery, crematory, or other place): Eternal Hills Crematory
37. Location: Klamath Falls, OR
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4): Eternal Hills Funeral Home 4711 HWY 39 Klamath Falls, OR 97603-9613
39. Date of Disposition (MON DD YYYY): October 8, 2008
40. Funeral Director's Signature: ▶ [signature]
41. OR License Number: 3224
42. Registrar's Signature: ▶ [signature]
43. Date Received (MON DD YYYY): OCT 15 2008
44. Local File Number: 531
45. Record Amendment

TO BE COMPLETED BY MEDICAL CERTIFIER

46. Was case referred to Medical Examiner? ☐ Yes ☒ No
47. Autopsy? ☐ Yes ☒ No
48. Were autopsy findings available to complete the cause of death? ☐ Yes ☒ No
49. Time of Death: 17:20 PM

CAUSE OF DEATH (See instructions and examples.)

50. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT ENTER TERMINAL EVENTS such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

Final disease or condition resulting in death → Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).		Approximate Interval: Onset to Death
IMMEDIATE CAUSE a.	hepatic encephalopathy	1 month
Due to (or as a consequence of) b.	cirrhosis	5 years
Due to (or as a consequence of) c.	alcohol abuse	20 years
Due to (or as a consequence of) d.		

51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:
52. Manner of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Undetermined ☐ Suicide ☐ Pending
53. If Female: ☒ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days before death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year
54. Did tobacco use contribute to death? ☐ Yes ☐ Probably ☐ No ☒ Unknown
55. Date of Injury (MON DD YYYY):
56. Time of Injury:
57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area):
58. Injury at Work? ☐ Yes ☐ No ☐ Unknown
59. Location of Injury (Number & Street, City/Town, State, Zip + 4):
60. Describe how injury occurred.
61. If transportation injury, specify. ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4): Gabriel Mayland 2074 South 6th St Klamath Falls, OR 97601-3372
63. Name and Title of Attending Physician if Other than Certifier
64. Title of Certifier: Medical Doctor
65. License Number: MD26937
66. Date Certified (MON DD YYYY): 10/6/08
67. Medical Certifier – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ▶ [signature]
68. Medical Examiner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ▶
69. Record Amendment

45-2 (0

ORIGINAL - VITAL RECORDS COPY

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

[signature]
ANGELICA MOLINA
COUNTY REGISTRAR
KLAMATH COUNTY, OREGON

DATE ISSUED: OCT 15 2008