2010-007988
Klamath County, Oregon

00086706201000079880040044

06/30/2010 03:34:23 PM Fee: $52.00

THIS SPACE F

After recording return to:
Keith Michael Thompson
PO Box 661496
Arcadia, CA 91066

Until a change is requested all tax statements shall be sent to the following address:
Keith Michael Thompson
PO Box 661496
Arcadia, CA 91066

File No.: 7021-1494445 (ALF)
Date: November 04, 2009

1st 1494445

STATUTORY WARRANTY DEED

Harriett Meininger, Grantor, conveys and warrants to **Keith Michael Thompson and David Robert Thompson and Elizabeth Jane Thompson, not as tenants in common but with full rights of survivorship** , 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 IN BLOCK 95 OF KLAMATH FALLS FOREST ESTATES HIGHWAY 66 UNIT, PLAT NO. 4 AS RECORDED IN 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 **$1,500.00**. (Here comply with requirements of ORS 93.030)

F

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 15th day of June, 2010.

Harriett Meininger

Harriett Meininger

STATE OF ~~Oregon~~ Missouri)
)ss.
County of ~~Klamath~~ Taney)

This instrument was acknowledged before me on this 15 day of June, 2010 by **Harriett Meininger**.

MELISSA DAWN BOX NOTARY PUBLIC NOTARY SEAL COMMISSION #06416256 MY COMMISSION EXPIRES 10/11/2010 STONE COUNTY STATE OF MISSOURI

Melissa Dawn Box

Notary Public for ~~Oregon~~ Missouri

My commission expires: 10/11/10

STATE OF OKLAHOMA
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

To be completed by the Funeral Home

Field	Entry
1. DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix)	CLAYTON Edward MEININGER
2. SEX	M
3. SOCIAL SECURITY NUMBER	565 84 8388
4. EVER IN US ARMED FORCES?	X Yes / No
5a AGE- Last Birthday (years)	58
5b. Under 1 Year (Months, Days)	
5c. Under 1 Day (Hours, Minutes)	
6. DATE OF BIRTH (Mo/Day/Yr)	8-7-1951
7. BIRTHPLACE (City, and State, or Foreign Country)	Charlotte North Carolina
8a. RESIDENCE-State	Oklahoma
8b. RESIDENCE-County	Latimer
8c. RESIDENCE-City or Town	Talihina
8d. RESIDENCE-Zip Code	74571
8e. RESIDENCE-Inside City Limits	Yes / X No
8f. RESIDENCE-Street and Number	End of Hwy 63A
8g. RESIDENCE-Apartment Number	
9. MARITAL STATUS AT TIME OF DEATH	Married / Never Married / Widowed / X Divorced / Married, but separated / Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)	None
11. FATHER'S NAME (First, Middle, Last)	Ronald Meininger
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)	Harriett Griffith

13. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the 'No' box if the decedent is not Spanish/Hispanic/Latino)
- [X] No, not Spanish/Hispanic/Latino
- [ ] Yes, Mexican, Mexican American, Chicano
- [ ] Yes, Puerto Rican
- [ ] Yes, Cuban
- [ ] Yes, other Spanish/Hispanic/Latino (specify) ______

14. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
- [X] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native (Name of entitled or principal tribe)
- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Other Asian (specify) ______
- [ ] Pacific Islander (specify) ______
- [ ] Other (specify) ______

15. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death)
- [ ] 8th grade or less
- [ ] 9th-12th grade, no diploma
- [X] High school graduate or GED completed
- [ ] Some college credit, but no degree
- [ ] Associate degree (e.g. AA, AS)
- [ ] Bachelor's degree (e.g. BA, AB, BS)
- [ ] Master's degree (e.g. MEd, MA, MEng, MSW, MBA)
- [ ] Doctorate or Professional Degree (e.g. PhD, EdD or MD, JD, etc.)

Field	Entry
16. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) DO NOT USE RETIRED.	laborer
17. KIND OF BUSINESS/INDUSTRY	general laborer
18a. INFORMANT'S NAME	Kevin Meininger
18b. RELATIONSHIP TO DECEDENT	brother
18c. MAILING ADDRESS (Street and Number, City, State, Zip Code)	47 Wintergreen Drive Blue Eyes M 65653
19. METHOD OF DISPOSITION	Burial / X Cremation / Donation / Entombment / Removal From State / Other (specify)
20. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)	Hunn Black& Merritt Crematory
21. LOCATION- City, Town and State	Eufaula Oklahoma
22. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY	TAlihina Funeral Home, P O Box 1059 Talihina Ok 74571
23. SIGNATURE OF FUNERAL HOME DIRECTOR OR FAMILY MEMBER ACTING AS SUCH	[signature]
24. FH ESTABLISHMENT LICENSE #	1273

To be completed by the Attending Physician or Medical Examiner

25. PLACE OF DEATH (Check only one: see instructions)
- IF DEATH OCCURRED IN A HOSPITAL: Inpatient / Emergency Room/Outpatient / Dead on Arrival
- IF DEATH OCCURRED OTHER THAN IN A HOSPITAL: Hospice / ✓ Nursing Home or Long Term Care Facility / Decedent's Home / Other (Specify)

Field	Entry
26. FACILITY NAME (If not institution, give street & number)	OKLAHOMA VETERANS CENTER
27. CITY OR TOWN, STATE AND ZIP CODE OF LOCATION OF DEATH	TALIHINA, OKLAHOMA
28. COUNTY OF DEATH	LATIMER
29. DATE OF DEATH (Mo/Day/Yr)	10/28/2009
30. TIME OF DEATH	08:56
31. WAS MEDICAL EXAMINER CONTACTED?	✓ Yes / No
32. WAS AN AUTOPSY PERFORMED?	Yes / ✓ No
33. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH?	Yes / No

CAUSE OF DEATH (See Instructions and Examples)

34. PART I. Enter the chain of events- diseases, injuries, or complications- that directly caused the death. DO NOT enter terminal events such as cardiac arrest or respiratory arrest, ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

	Cause	Approximate interval: Onset to death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	Undetermined
Sequentially list conditions, if any, leading to immediate cause listed on line a. b.	Due to (or as a consequence of):	
Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST. c.	Due to (or as a consequence of):	
d.	Due to (or as a consequence of):	

0960898

35. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
DAIBETES MELLITUS, HYPERTENSION

36. MANNER OF DEATH: ✓ Natural / Homicide / Accident / Suicide / Pending Investigation / Could not be determined

37. IF FEMALE: Not pregnant within past year / Pregnant at time of death / Not pregnant, but pregnant within 42 days of death / Not pregnant, but pregnant 43 days to 1 year before death / Unknown if pregnant within the past year

38. DID TOBACCO USE CONTRIBUTE TO DEATH? Yes / No / Probably / ✓ Unknown

39. DATE OF INJURY (Mo/Day/Yr) | 40. TIME OF INJURY | 41. PLACE OF INJURY (e.g. Decedent's home; construction site; wooded area) | 42. DESCRIBE HOW INJURY OCCURRED | 43. INJURY AT WORK: Yes / No

44. LOCATION OF INJURY: State: City or Town: Zip Code: Street & Number: Apartment Number:

45. IF TRANSPORTATION INJURY, SPECIFY: Driver/Operator / Passenger / Pedestrian / Other (specify)

46. CERTIFIER (Check only one):
ATTENDING PHYSICIAN: Physician in charge of the patient's care / Physician in attendance at time of death only.
To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) and manner as stated.
✓ 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.

Signature of Certifier: [signature]

47. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 34): ERIC DUVAL D.O., 901 N. STONEWALL, OKLAHOMA CITY, OK, 73117

48. LICENSE NUMBER: 4399

49. DATE CERTIFIED (Mo/Day/Yr): 10/29/2009

50. REGISTRAR'S SIGNATURE (Local): [signature]

51. DATE RECEIVED BY LOCAL REGISTRAR (Mo/Day/Yr): NOV 13 2009

52. DATE RECEIVED BY STATE REGISTRAR (Mo/Day/Yr):

2004 REVISION | VS 154 (1-04

NOVEMBER 13 , 2009

TYPE/PRINT IN PERMANENT BLACK INK. FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK.

VS 300

MO 580-2211 (11-97)

FOR USE BY PHYSICIAN OR INSTITUTION

NAME OF DECEDENT

MISSOURI DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER 124 -

REGISTRATION DISTRICT NO. 209 REGISTRAR'S NUMBER 64

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last): RONALD MEININGER
2. SEX: MALE
3. DATE OF DEATH (Month, Day, Year): MAY 13, 2002
4. SOCIAL SECURITY NO.: 539-18-8605
5a. AGE - Last Birthday (Years): 76
5b. UNDER 1 YEAR: MONTHS / DAYS
5c. UNDER 1 DAY: HOURS / MINUTES
6. DATE OF BIRTH (Month, Day, Year): APRIL 4, 1926
7. BIRTHPLACE (City and State or Foreign Country): TACOMA, WASHINGTON
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] Yes [ ] No [ ] Unk.
9a. PLACE OF DEATH (Check only one; see instructions on other side) HOSPITAL: [ ] Inpatient [ ] ER/Outpatient [ ] DOA OTHER: [ ] Nursing Home [X] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 47 WINTERGREEN DRIVE
9c. CITY, TOWN, OR LOCATION OF DEATH: BLUE EYE
9d. COUNTY OF DEATH: STONE
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify): MARRIED
11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name): HARRIETT GRIFFITH
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): MILITARY
12b. KIND OF BUSINESS OR INDUSTRY: NAVY
13a. RESIDENCE - STATE: MISSOURI
13b. COUNTY: STONE
13c. CITY, TOWN, OR LOCATION: BLUE EYE
13d. ZIP CODE: 65611
13e. STREET AND NUMBER: 47 WINTERGREEN DR
13f. INSIDE CITY LIMITS: 1 [ ] Yes 2 [X] No
13g. YEARS AT PRESENT ADDRESS: 1 [ ] Under 5 2 [ ] 5-9 3 [X] 10-19 4 [ ] 20 or more
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): 0 [X] No [ ] Yes Specify:
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+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): JACOB MEININGER
18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN MUNTZ

INFORMANT

19a. INFORMANT'S NAME (Type/Print): HARRIETT MEININGER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 WINTERGREEN DRIVE BLUE EYE, MISSOURI 65611

DISPOSITION

20a. BURIAL, CREMATION, OTHER (Specify): BURIAL
20b. DATE OF DISPOSITION (Month, Day, Year): MAY 17, 2002
20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): WHITE CHAPEL MEMORIAL GARDENS
20d. LOCATION - City or Town, State: SPRINGFIELD, MISSOURI
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: ► Nancy Chaney
22a. NAME AND ADDRESS OF FACILITY: 708 STATE HIGHWAY 248 GREENLAWN FUNERAL HOME BRANSON, MO. 65616
22b. FUNERAL ESTABLISHMENT LICENSE NUMBER: 1904

CAUSE OF DEATH

SEE INSTRUCTIONS ON OTHER SIDE

23. 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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Heart Failure	2wks
DUE TO (OR AS A CONSEQUENCE OF):	b. ASHD.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	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. Renal insufficiency COPD

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? [ ] Yes [ ] No [ ] Unk.
25a. WAS AN AUTOPSY PERFORMED? [ ] Yes [X] No
25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [ ] Yes [ ] No
26. MANNER OF DEATH: [X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide
27a. DATE OF INJURY (Month, Day, Year)
27b. TIME OF INJURY: M
27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent.) [ ] Yes [ ] No [ ] Unk.
27d. INJURY AT WORK? [ ] Yes [ ] No [ ] Unk.
27e. DESCRIBE HOW INJURY OCCURRED
27f. PLACE OF INJURY - At home, farm street, factory, office building, etc. (specify)
27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER

28a. (Specify) [X] CERTIFYING PHYSICIAN [ ] MEDICAL EXAMINER/CORONER
28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ► Robert P. Saylor, M.D.
28c. DATE SIGNED (Month, Day, Year): 5/15/02
28d. TIME OF DEATH: 8:37 P. M
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print): DR. ROBERT SAYLOR MD SPRINGFIELD, MO. 65804
29b. MO LICENSE NUMBER: MDR4J58
30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? [ ] Yes [X] No
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
32. REGISTRAR'S SIGNATURE: ► Brenda Smithson
33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year): 05-16-02

THIS IS A CERTIFIED COPY OF AN ORIGINAL DOCUMENT.
(Do not accept if rephotographed, or if seal impression cannot be felt.)

THE REPRODUCTION OF THIS DOCUMENT IS PROHIBITED BY LAW (sec. 193.245, 193.255, & 193.315 RSMo 1994)

STATE OF MISSOURI } ss
County of Stone

I HEREBY CERTIFY that this is an exact reproduction of the certificate for the person named therein as it now appears in the permanent records of the Bureau of Vital Records of the Missouri Department of Health. Witness my hand as County Registrar of Vital Statistics and the Seal of the Missouri Department of Health this date of

05-16-02

Brenda Smithson
Registrar of Vital Statistics

MO 580-1103 (6/99)