

2010-007988

Klamath County, Oregon



00086706201000079880040044

THIS SPACE F

06/30/2010 03:34:23 PM

Fee: \$52.00



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)

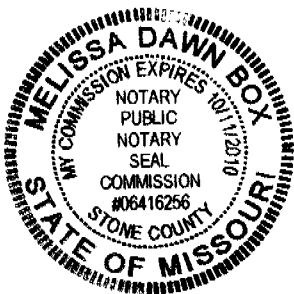
BEFORE SIGNING OR ACCEPTING THIS INSTRUMENT, THE PERSON TRANSFERRING FEE TITLE SHOULD INQUIRE ABOUT THE PERSON'S RIGHTS, IF ANY, UNDER ORS 195.300, 195.301 AND 195.305 TO 195-336 AND SECTIONS 5 TO 11, OF CHAPTER 424, OREGON LAWS 2007. THIS INSTRUMENT DOES NOT ALLOW USE OF THE PROPERTY DESCRIBED IN THIS 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 15<sup>th</sup> day of June, 20 10.

Harriett Meininger  
Harriett Meininger

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

This instrument was acknowledged before me on this 15 day of June, 20 10  
by **Harriett Meininger**.



Melissa Dawn Box  
Missouri

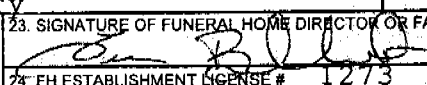
Notary Public for ~~Oregon~~

My commission expires: 10/11/10

# STATE OF OKLAHOMA CERTIFICATE OF DEATH

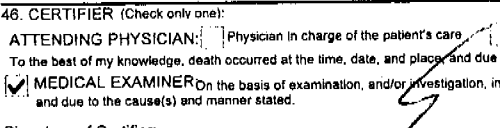
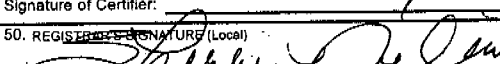
LOCAL FILE NUMBER

STATE FILE NUMBER

1. DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix) <b>CLAYTON Edward MEININGER</b>				2. SEX <b>M</b>		3. SOCIAL SECURITY NUMBER <b>565 84 8388</b>		4. EVER IN US ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
5a. AGE- Last Birthday (years) <b>58</b>		5b. Under 1 Year Months <b>Days</b>		5c. Under 1 Day Hours <b>Minutes</b>		6. DATE OF BIRTH <b>8-7-1951</b>		7. BIRTHPLACE (City, and State, or Foreign Country) <b>Charlotte North Carolina</b>	
8a. RESIDENCE-State <b>Oklahoma</b>			8b. RESIDENCE-County <b>Latimer</b>			8c. RESIDENCE-City or Town <b>Talihina</b>		8d. RESIDENCE-Zip Code <b>74571</b>	
8e. RESIDENCE-Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								8f. RESIDENCE-Street and Number <b>End of Hwy 63A</b>	
8g. RESIDENCE-Apartment Number								9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Married, but separated <input type="checkbox"/> Unknown	
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage) <b>None</b>								11. FATHER'S NAME (First, Middle, Last) <b>Ronald Meininger</b>	
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <b>Harriett Griffith</b>								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) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> 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) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of entitled or principal tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Pacific Islander (specify) _____ <input type="checkbox"/> 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) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th-12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's degree (e.g. MEd, MA, MEng, MSW, MBA) <input type="checkbox"/> Doctorate or Professional Degree (e.g. PhD, EdD or MD, JD, etc.)	
16. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life.) DO NOT USE RETIRED. <b>laborer</b>						17. KIND OF BUSINESS/INDUSTRY <b>general laborer</b>			
18a. INFORMANT'S NAME <b>Kevin Meininger</b>				18b. RELATIONSHIP TO DECEDENT <b>brother</b>		18c. MAILING ADDRESS (Street and Number, City, State, Zip Code) <b>65653 47 Wintergreen Drive Blue Eyes</b>			
19. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (specify) _____				20. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) <b>Hunn Black&amp; Merritt Crematory</b>				21. LOCATION- City, Town and State <b>Eufaula Oklahoma</b>	
22. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY <b>Talihina Funeral Home P O Box 1059 Talihina Ok 74571</b>						23. SIGNATURE OF FUNERAL HOME DIRECTOR OR FAMILY MEMBER ACTING AS SUCH 			
24. FH ESTABLISHMENT LICENSE # <b>1273</b>									

To be completed by the Funeral Home

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: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Hospice <input checked="" type="checkbox"/> Nursing Home or Long Term Care Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify) _____									
26. FACILITY NAME (If not institution, give street & number) <b>OKLAHOMA VETERANS CENTER</b>				27. CITY OR TOWN, STATE AND ZIP CODE OF LOCATION OF DEATH <b>TALIHINA, OKLAHOMA</b>				28. COUNTY OF DEATH <b>LATIMER</b>	
29. DATE OF DEATH <b>10/28/2009</b> (Mo/Day/Yr)		30. TIME OF DEATH <b>08:56</b>		31. WAS MEDICAL EXAMINER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		32. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		33. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p style="text-align: center;"><b>CAUSE OF DEATH (See Instructions and Examples)</b></p> <p>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.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death)      a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b></p> <p>Due to (or as a consequence of): _____</p> <p>Sequentially list conditions, if any, leading to immediate cause listed on line a.      b. _____</p> <p>Due to (or as a consequence of): _____</p> <p>Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.      c. _____</p> <p>Due to (or as a consequence of): _____</p> <p>d. _____</p> <p><b>0960898</b></p>									
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				37. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year				38. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	
44. LOCATION OF INJURY: State: _____ City or Town: _____ Zip Code: _____ Street & Number: _____ Apartment Number: _____				45. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (specify) _____					
46. CERTIFIER (Check only one): ATTENDING PHYSICIAN: <input type="checkbox"/> Physician in charge of the patient's care <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 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: 						47. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 34) <b>ERIC DUVAL D.O., 901 N. STONEWALL, OKLAHOMA CITY, OK, 73117</b>			
48. LICENSE NUMBER <b>4399</b>				49. DATE CERTIFIED <b>10/29/2009</b> (Mo/Day/Yr)		50. REGISTERED SIGNATURE (Local) 			
51. DATE RECEIVED BY LOCAL REGISTRAR <b>NOV 13 2009</b> (Mo/Day/Yr)				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.

MISSOURI DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

STATE FILE NUMBER

REGISTRATION DISTRICT NO. <b>209</b>		REGISTRAR'S NUMBER <b>64</b>		124 -	
1. DECEDENT'S NAME (First, Middle, Last) <b>RONALD MEININGER</b>				2. SEX <b>MALE</b>	3. DATE OF DEATH (Month, Day, Year) <b>MAY 13, 2002</b>
4. SOCIAL SECURITY NO. <b>539-18-8605</b>	5a. AGE - Last Birthday (Years) <b>76</b>	5b. UNDER 1 YEAR MONTHS <b>76</b>	5c. UNDER 1 DAY HOURS <b>76</b>	6. DATE OF BIRTH (Month, Day, Year) <b>APRIL 4, 1926</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>TACOMA, WASHINGTON</b>
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.					
9a. PLACE OF DEATH (Check only one; see instructions on other side) <b>HOSPITAL:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <b>OTHER:</b> <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
9b. FACILITY NAME (If not institution, give street and number) <b>47 WINTERGREEN DRIVE</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>BLUE EYE</b>		9d. COUNTY OF DEATH <b>STONE</b>
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify) <b>MARRIED</b>		11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) <b>HARRIETT GRIFFITH</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>MILITARY</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>NAVY</b>		13a. RESIDENCE - STATE <b>MISSOURI</b>		13b. COUNTY <b>STONE</b>	
13c. STREET AND NUMBER <b>47 WINTERGREEN DR</b>		13d. ZIP CODE <b>65611</b>		13e. YEARS AT PRESENT ADDRESS <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input checked="" type="checkbox"/> 11-15 <input type="checkbox"/> 16-20 <input type="checkbox"/> 21 or more	
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:		15. RACE - American Indian, Black, White, etc. (Specify) <b>WHITE</b>		16. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>-12-</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JACOB MEININGER</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN MUNTZ</b>		
19a. INFORMANT'S NAME (Type/Print) <b>HARRIETT MEININGER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>47 WINTERGREEN DRIVE BLUE EYE, MISSOURI 65611</b>			
20a. BURIAL, CREMATION, OTHER (Specify) <b>BURIAL</b>		20b. DATE OF DISPOSITION (Month, Day, Year) <b>MAY 17, 2002</b>		20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>WHITE CHAPEL MEMORIAL GARDENS</b>	
20d. LOCATION - City or Town, State <b>SPRINGFIELD, MISSOURI</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Denny Chaney</i>		22a. NAME AND ADDRESS OF FACILITY <b>708 STATE HIGHWAY 248 GREENLAWN FUNERAL HOME BRANSON, MO. 65616</b>	
22b. FUNERAL ESTABLISHMENT LICENSE NUMBER <b>1904</b>		23. PART I. Enter the disease, 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. <b>Heart Failure</b> <b>AS + D</b>			
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Heart Failure</b>		Approximate Interval Between Onset and Death <b>2 weeks</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST <b>AS + D</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal insufficiency</b> <b>COPD</b>					
24. IF DECEDENT WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year) <b>M</b>		27b. TIME OF INJURY <b>M</b>	
27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)			
28a. (Specify) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> 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) <i>Robert P. Saylor, M.D.</i>		28c. DATE SIGNED (Month, Day, Year) <b>5/15/02</b>	
28d. TIME OF DEATH <b>8:37 P. M</b>					
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print) <b>DR. ROBERT SAYLOR MD SPRINGFIELD, MO. 65804</b>		29b. MO. LICENSE NUMBER <b>MDR4J58</b>		30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		32. REGISTRAR'S SIGNATURE <i>Brenda Smithson</i>		33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year) <b>05-16-02</b>	

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