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2013-000408

Klamath County, Oregon

01/11/2013 09:01:39 AM

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## CERTIFICATION OF VITAL RECORD

OREGON DEPARTMENT OF HUMAN SERVICES

CENTER FOR HEALTH STATISTICS

136-

601407

I.D. TAG NO.

STATE FILE NUMBER

1. Legal Name (First, Middle, Last, Suffix) <b>Alma Lee TECUMSEH</b>			2. Death Date (MON DD YYYY) <b>December 6, 2011</b>		
3. Sex (MF) <b>F</b>	4a. Age - Last Birthday <b>72</b>	4b. Under 1 Year Months: Days:	4c. Under 1 Day Hours: Minutes:	5. Social Security Number <b>544-42-9351</b>	6. County of Death <b>Klamath</b>
7. Birthdate (MON DD YYYY) <b>June 14, 1939</b>		8a. Birthplace (City/Town, or County) <b>DeQueen</b>		8b. (State or Foreign Country) <b>Arkansas</b>	
9. Decedent's Education <b>High School-Diploma</b>			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.) <b>No</b>			11. Decedent's Race(s) <b>White</b>		
13. Residence Number and Street (e.g., 624 SE 5th Street, Apt. No. 8) <b>4015 Jana Drive</b>			14. City/Town <b>Klamath Falls</b>		
15. Residence County <b>Klamath</b>		16. State or Foreign Country <b>Oregon</b>		17. Zip Code + 4 <b>97603-9488</b>	
18. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. Marital Status at Time of Death <b>Married</b>			20. Spouse's Name (If married or widowed, give name prior to first marriage) <b>Stanley Lewis Tecumseh</b>		
21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.") <b>Bookkeeping</b>			22. Kind of Business/Industry (DO NOT USE COMPANY NAME.) <b>Retail Stores</b>		
23. Father's Name (First, Middle, Last, Suffix) <b>John Roger Chronister</b>			24. Mother's Name Prior to First Marriage (First, Middle, Last) <b>Alice Williamson</b>		
25. Informant's Name <b>Stanley L. Tecumseh</b>		26. Telephone Number <b>541-882-4898</b>		27. Relation to Decedent <b>Husband</b>	
28. Mailing Address (Number & Street, City/Town, State, Zip + 4) <b>4015 Jana Drive, Klamath Falls, OR 97603-</b>					
29. Place of Death <b>Decedent's Residence - Hospice</b>		30. Facility Name <b>" "</b>			
31. Location of Death (Give address) <b>4015 Jana Drive</b>		32. City/Town or Location of Death <b>Klamath Falls</b>		33. State <b>OR</b>	
34. Zip Code + 4 <b>97603-9488</b>					
35. Method of Disposition <b>Burial</b>		36. Place of Disposition (Name of cemetery, crematory, or other place) <b>Eternal Hills Memorial Gardens</b>		37. Location <b>Klamath Falls, OR</b>	
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4) <b>Davenport's Chapel of the Good Shepherd, 2680 Memorial Dr., Klamath Falls, OR 97601-5546</b>					
39. Date of Disposition (MON DD YYYY) <b>December 12, 2011</b>		40. Funeral Director's Signature <i>[Signature]</i>		41. OR License Number <b>CO-3104</b>	
42. Registrar's Signature <i>[Signature]</i>		43. Date Received (MON DD YYYY) <b>DEC 12 2011</b>		44. Local File Number <b>231</b>	
45. Record Amendment					
46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
47. Autopsy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
48. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
49. Time of Death <b>0742</b>					
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 →		IMMEDIATE CAUSE →			
Sequentially list conditions, if any, leading to the cause listed on line a.		a. <b>Anemia</b>			
ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).		b. <b>Lymphoma</b>			
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:					
52. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		53. If Female <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death		54. Did tobacco use contribute to death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
59. Location of Injury (Number & Street, City/Town, State, Zip + 4)					
60. Describe how injury occurred.					
61. If transportation injury, specify. <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)					
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4) <b>Charles L. Christensen, MD 2684 Campus Drive, Klamath Falls, OR 97601-1105</b>					
63. Name and Title of Attending Physician if Other than Certifier					
64. Title of Certifier <b>Medical Doctor</b>		65. License Number <b>MD# 12776</b>		66. Date Signed (MON DD YYYY) <b>December 10, 2011</b>	
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.					
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					

ORIGINAL - VITAL RECORDS COPY

45-2 (06/06)

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE OR THE VITAL RECORD FACTS ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON CENTER FOR HEALTH STATISTICS.

DEC 12 2011

DATE ISSUED:

JENNIFER A. WOODWARD, Ph.D.

STATE REGISTRAR

THIS COPY IS NOT VALID WITHOUT INTAGLIO, STATE SEAL AND BORDER

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE