

# STATE OF OREGON

## CERTIFICATION OF VITAL RECORD

### OREGON HEALTH AUTHORITY CENTER FOR HEALTH STATISTICS CERTIFICATE OF DEATH

765148  
I.D. TAG NO.

STATE FILE NUMBER

1. Legal Name First: Carl, Middle: Norman, Last: Nielsen, Suffix:				2. Death Date September 26, 2016	
3. Sex Male		4. Age 91 years		5. Social Security Number 544-14-3662	
6. County of Death Lane		7. Birthdate November 24, 1924		8. Birthplace Askov, Minnesota	
9. Decedent's Education High school grad. or GED		10. Was Decedent of Hispanic Origin? No		11. Decedent's Race(s) White	
12. Was Decedent Ever in U.S. Armed Forces? Yes		13. Residence: Number and Street 1202 Jacobs Drive 249		14. City/Town Eugene	
15. Residence County Lane		16. State or Foreign Country Oregon		17. Zip Code + 4 97402	
18. Inside City Limits? Yes		19. Marital Status at Time of Death Married		20. Spouse's Name Prior to First Marriage Enola Jean Kloster	
21. Usual Occupation Lumber Carrier Driver		22. Kind of Business/Industry Lumber Production		23. Father's Name Jorgen Nielsen	
24. Mother's Name Prior to First Marriage Anna B. Lund		25. Informant's Name Enola Nielsen		26. Telephone Number Not Available	
27. Relationship to Decedent Spouse		28. Mailing Address 1202 Jacobs Drive 249, Eugene, OR 97402		29. Place of Death Decedent's Residence - Hospice	
30. Facility Name		31. Location of Death 1202 Jacobs Drive 249		32. City/Town or Location of Death Eugene	
33. State Oregon		34. Zip Code + 4 97402		35. Method of Disposition Cremation	
36. Place of Disposition Willamette Valley Crematory		37. Location Eugene, Oregon		38. Name and Complete Address of Funeral Facility Murphy-Musgrove Funeral Home, 480 W 7th Street, Junction City, Oregon 97448	
39. Date of Disposition TBD		40. Funeral Director's Signature Robert A McCune Jr		41. OR License Number CO-3864	
42. Registrar's Signature Virginia Sandoval		43. Date Received SEP 29 2016		44. Local File Number 3136	
45. Amendment					

\*6784585\*

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 2042	
CAUSE OF DEATH							
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.						Approximate Interval: Onset to Death	
Final disease or condition resulting in death →		IMMEDIATE CAUSE ↓				Minutes	
a. Due to (or as a consequence of) ↓		CARDIAC ARREST				MONTHS	
b. Due to (or as a consequence of) ↓		UNKNOWN PULMONARY MASS				MONTHS	
c. Due to (or as a consequence of) ↓		WITH UNKNOWN RENAL MASS				MONTHS	
d. Due to (or as a consequence of) ↓							
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above: TIA's, Atrial Fibrillation							
52. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		53. If Female <input 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"/> No <input 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 type="checkbox"/> No <input type="checkbox"/> Unknown	
59. Location of Injury (Number & Street or RFD No., 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 or RFD No., City/Town, State, Zip + 4) DEREK D MENPORT 4135 QUEST DRIVE, EUGENE OR 97402							
63. Name and Title of Attending Physician if Other than Certifier							
64. Title of Certifier MD				65. License Number MD142235		66. Date Signed (MON DD YYYY) 9/28/2016	
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. Amendment							

45-2DP (01/06)

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.

DATE ISSUED: SEP 29 2016

Jennifer A. Woodward  
JENNIFER A. WOODWARD, Ph.D.  
STATE REGISTRAR

THIS COPY IS NOT VALID WITHOUT OFFICIAL VITAL RECORD FLAG WATERMARK AND HOLOGRAPHIC SEALS.

