



Oklahoma State Health Department

State of Oklahoma
OKLAHOMA CITY

STANDARD CERTIFICATE OF BIRTH Oklahoma State Board of Health BUREAU OF VITAL STATISTICS OKLAHOMA CITY, OKLA.

Register No. 8-1338

1. PLACE OF BIRTH

County Adair
Township Bayou
or
Village Adair
or

Registration
Dist. No.

Primary
Dist. No.

City _____ No. _____ Street _____ Ward _____
(If in a hospital or other institution, the name of the same to be given instead of the street and house number.)

2. FULL NAME OF CHILD Samuel Blair
(If the child dies without a name before the certificate is filed enter the words: "Died unnamed." If the living child has not yet been named at the date of filing certificate of birth the space for "Full name of child" is to be left blank, to be filled out separately by a supplemental report.)

3. Sex of child. <u>male</u>	4. Twins, Triplets or others. (To be answered only in event of plural births.)	5. Number in order of birth.	6. Legitimate? <u>yes</u>	7. Date of Birth <u>8/15/25</u> (month) (day) (yr.)
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8. Full name FATHER
J. G. Kirk
9. Residence Adair
10. Color or race white
11. Age at last birthday 34 years.
12. Birthplace, at least state or foreign country, if known
13. Occupation Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or other establishment in which employed (or employer)

14. Full maiden name MOTHER
Bella Wheat
15. Residence Adair
16. Color or race white
17. Age at last birthday 32 years.
18. Birthplace, at least state or foreign country, if known
19. Occupation Not in service
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or other establishment in which employed (or employer)

20. Number of children born to this mother, including present birth 3
21. Number of children of this mother now living 3

22. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was (1) _____ (Born alive or stillborn) at 3 P. M.
on the date above stated.
(1) When there was no attending physician or midwife, then the father, householders, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give name added from supplemental report.

Address Adair Okla
Filed 1925 _____ 19 _____
(Physician or Midwife.)

23. Did you use a one or two per cent silver nitrate solution in this infant's eye immediately after its birth?
Yes _____ No _____ Registrar.

I do hereby certify the foregoing to be a true and correct copy, original of which is on file in this office.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and caused the official seal to be affixed, at Oklahoma City, Oklahoma, this 21 day of MAY 1943.

J. G. Hargrave
STATE REGISTRAR

STATE OF OREGON
 OREGON STATE HEALTH DIVISION
 DEPARTMENT OF HUMAN RESOURCES
 Vital Records Unit

CERTIFICATE OF DEATH

ORS - 146

Local File Number				State File Number				
NAME - FIRST MIDDLE LAST TOM JUNIOR RINK						DATE OF DEATH (MONTH, DAY, YEAR) June 14, 1984		
RACE - BLACK, AMERICAN (SPECIFY)		SEX Male	AGE - LAST BIRTHDAY (YEARS) 58		UNDER 1 YEAR MOS. DAYS		UNDER 1 DAY HOURS MIN.	
DATE OF BIRTH (MONTH, DAY, YEAR) September 15, 1925		HOSPITAL OR OTHER INSTITUTION - NAME (IF NOT IN EITHER, GIVE STREET & NO.) West Medical Center		IF HOSP. OR INST. INDICATE - DOA, OP, EMER. RM., INPATIENT (SPECIFY) Emer. Room		COUNTY OF DEATH Klamath		
CITY, TOWN, OR LOCATION OF DEATH Klamath Falls		CITIZEN OF WHAT COUNTRY U.S.A.		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) Divorced		SPOUSE (IF MARRIED, WIDOWED) -		
WAS DECEDENT EVER IN U.S. ARMED FORCES? (SPECIFY YES OR NO) Yes		USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Disabled		KIND OF BUSINESS OR INDUSTRY -				
CURRICULAR NUMBER 20 / 4804		CITY, TOWN, OR LOCATION Klamath		STREET AND NUMBER OR R.F.D. ZIP 4246 Tingley Lane/97603		INSIDE CITY LIMITS (SPECIFY YES OR NO) No		
MOTHER - FIRST MIDDLE LAST Della Wheat		INFORMANT - NAME AND RELATIONSHIP TO DECEASED Jimmie Dee Graham /Sis						
CEMETERY OR CREMATORY - NAME Klamath Memorial Park		LOCATION - CITY OR TOWN STATE Klamath Falls, Ore						
WARD'S - 1945 Main - Klamath Falls, Oregon 97601								
AT 1 MADE INQUIRY INTO THE DEATH OF THE DECEASED PERSON DESCRIBED ABOVE, AND IN MY OPINION DEATH RESULTED ON OR ABOUT: OCCURRED THE DECEDENT WAS PRONOUNCED DEAD FROM:								
DATE June 14, 1984 / 9:34a		NATURAL CAUSES <input checked="" type="checkbox"/>		ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		
		HOMICIDE <input type="checkbox"/>		UNDETERMINED <input type="checkbox"/>		PENDING <input type="checkbox"/>		
SIGNATURE <i>George R. Nicholson</i>		NAME - (TYPE OR PRINT) George R. Nicholson, MD		DEGREE OR TITLE				
COUNTY Klamath		DATE SIGNED (MONTH, DAY, YEAR) 06-18-84						
RECEIVED BY REGISTRAR (MO., DAY, YR.)		REGISTRAR (SIGNATURE)						
CAUSE Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH				INTERVAL BETWEEN		

540-20-4804

SOCIAL SECURITY ACCOUNT NUMBER

Tom Junior Rink

Rt. 3, Box 37

Klamath Falls, Oregon

WORKER'S NAME AND HOME ADDRESS

Tom Junior Rink

EMPLOYER'S NAME

IF WORKER'S NAME IS CHANGED MAKE REQUEST FOR ACCOUNT NUMBER CARD BEARING NEW NAME ON FORM OAAAN-7003 WHICH MAY BE SECURED FROM ANY SOCIAL SECURITY BOARD FIELD OFFICE.