SK-14974/ES-665

105763 40430
ID TAG NO.

85-88
Local File Number

OREGON STATE HEALTH DIVISION BOOK 110 PAGE 815
DEPARTMENT OF HUMAN RESOURCES
Vital Records Unit
136-
State File Number

CERTIFICATE OF DEATH

1 DECEDENT'S NAME (First / Middle / Last)			2 SEX	3 DATE OF DEATH (Month, Day, Year)
John	Walter	GOSNELL	M	Aug. 15, 1988

4 SOCIAL SECURITY NUMBER	5a AGE - Last Birthday (Years)	5b UNDER 1 YEAR (Mos / Days)	5c UNDER 1 DAY (Hours / Mins.)	6 BIRTHPLACE (City and State or Foreign Country)	7 DATE OF BIRTH (Month, Day, Year)
[redacted]	84			Prairie Depot, OH	Jan. 27, 1904

8 WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No

9a PLACE OF DEATH (Check only one): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA | OTHER ☐ Nursing Home ☐ Decedent's Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
Hood River Memorial Hospital	Hood River	Hood River

10a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	10b KIND OF BUSINESS/INDUSTRY	11 MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	12 SPOUSE (If Married, Widowed)
Forester	U.S. Forest Service	Married	Ruth

13a RESIDENCE - STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Washington	Skamania	Stevenson	209 Loop Road

13e INSIDE CITY LIMITS?	13f ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15 RACE American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed)	
				Elementary/Secondary (0-12)	College (1-4 or 5+)
☒ Yes ☐ No	98648	☐ No ☐ Yes Specify	White		4

17 FATHER - NAME first middle last	18 MOTHER - NAME first middle maiden	19 INFORMANT - NAME and relationship to deceased
Earl Otto Gosnell	Martha E. Gorton	Martha Turnbull, Daughter

20a METHOD OF DISPOSITION	20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION - City or Town, State
☐ Mausoleum ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Stevenson Cemetery	Stevenson, WA

21 SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b LICENSE NUMBER (Of Licensee)	22 NAME, ADDRESS AND ZIP OF FACILITY
[signature]	1482	Gardner Funeral Home, Inc. Box 390 White Salmon, WA 98672

TO BE COMPLETED BY CERTIFYING PHYSICIAN

23 TIME OF DEATH	24 WAS MEDICAL EXAMINER NOTIFIED?
1606 M	☐ Yes ☒ No

25 To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) stated. (Signature) [signature]

26 DATE SIGNED (Month, Day, Year) aug. 17 1988

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

27a TIME OF DEATH	27b DATE PRONOUNCED DEAD (Month, Day, Year, Hour)
M	M

28 On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) stated. (Signature)

29 DATE SIGNED (Month, Day, Year) COUNTY

30 NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): James B. Wade, M.D. 1021 June Street Hood River, OR 97031

31 NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

32 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest

PART I		Interval between onset and death
(a)	CEREBRAL VASCULAR OCCLUSION	20 Hrs.
(b) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death
(c) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART 1 (a): CANCER PROSTATE Diabetes - Compensated Controlled Not Treated

33 AUTOPSY	34 IF YES were findings considered in determining cause of death?
☐ Yes ☒ No	

35 MANNER OF DEATH	36a DATE OF INJURY (Month, Day, Year)	36b TIME OF INJURY	36c INJURY AT WORK?	36d DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner		M	☐ Yes ☐ No	
	36e PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			36f LOCATION (Street and Number or Rural Route Number, City or Town, State)

37 REGISTRAR'S SIGNATURE [signature]

38 DATE FILED (Month, Day, Year) AUG 17 1988

39 DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT?	40 WAS GIFT MADE?
☐ YES ☐ NO ☐ N/A not available	☐ YES ☒ NO ☐ N/A

RESERVED FOR REGISTRAR'S USE

FILED FOR RECORD
SKAMANIA CO. WASH
BY SKAMANIA CO. TITLE
SEP 9 2 27 PM '88
[signature], Dep
AUDITOR
GARY M. OLSON

ORIGINAL—VITAL STATISTICS COPY

STATE OF OREGON

COUNTY OF HOOD RIVER

This certifies that the foregoing is a correct and complete transcript of a record of death on file with the HOOD RIVER COUNTY PUBLIC HEALTH DEPARTMENT.

[signature]
County Registrar of Vital Statistics

August 17, 1988
DATE

Registered S
Death Cer S
S

NOT VALID WITHOUT RAISED SEAL OF HOOD RIVER COUNTY HEALTH DEPARTMENT