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BOOK 115 PAGE 739

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SKAMANIA CO. WASH
BY Evelyn Amundson
SEP 5 9 47 AM '89
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24062 ID TAG NO.

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

CERTIFICATE OF DEATH

Local File Number

State File Number

TYPE OR PRINT IN PERMANENT BLACK INK — FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT

IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF EVIDENCE ITEMS

DECEASED — NAME First	Middle	Last	DATE OF DEATH (month, day, year)
1 ELIAS	OLIVER	AMUNDSON	2 January 31, 1987

RACE White, Black, American Indian, etc (specify)	SEX	AGE — Last birthday (years)	Under 1 year: mos / days	Under 1 day: hours / min	DATE OF BIRTH (month, day, year)
3 white	4 male	5a 73	5b	5c	6 Jan. 17, 1914

CITY, TOWN OR LOCATION OF DEATH	HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number)	IF HOSP OR INST Indicate DOA, OP, Emer. Rm., Inpatient (specify)	COUNTY OF DEATH
7a Portland	7b Portland VA Medical Center	7c Inpatient	7d Multnomah

STATE OF BIRTH (If not in U.S.A. name country)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	SPOUSE (IF MARRIED, WIDOWED)	WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no)
8 Canada	9 USA	10 married	11 Evelyn M. Irish	12 YES

SOCIAL SECURITY NUMBER	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	KIND OF BUSINESS OR INDUSTRY
13 556 24 3720	14a carpenter	14b house builder

RESIDENCE — STATE	COUNTY	CITY, TOWN OR LOCATION	STREET AND NUMBER OR R.F.D. ZIP	Inside City Limits (specify yes or no)
15a Washington	15b Skamania	15c Washougal	15d MP 2.59 Bell Center Rd. 98671	15e YES

FATHER — NAME first middle last	MOTHER — first middle last (Maiden Name)	INFORMANT — NAME and relationship to deceased
16 Anton Amundson	17 Anna Ronnigen	18 Evelyn Amundson, wife

BURIAL, CREMATION, REMOVAL, MAUS. (specify)	CEMETERY OR CREMATORY — NAME	LOCATION city or town, state
19a removy/burial	19b Evergreen Memorial Gardens Cemetery	19c Vancouver, Wash.

FUNERAL SERVICE LICENSEE or person acting as such (Signature)	NAME AND ADDRESS OF FACILITY
20a Randall Strauss	20b Memorial Gard. Funeral Ch. 1101 NE 112th Ave. Vanc. WA

POSITION

1 ____
2 ____
3 ____

CERTIFIER

To the Completing Physician or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated

21a (Signature)	DATE SIGNED (Mo., Day, Year)	HOUR OF DEATH
Anthony T. Hlinka	21b 2/2/87	21c 1:30pm

NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print)
21d Hlinka, Anthony T. M.D.
Portland VA Medical Center
3710 SW US Veterans Hospital Road
PO Box 1034
Portland OR 97207 ZIP

NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
21e

DATE RECEIVED BY REGISTRAR (Mo., Day, Year)	REGISTRAR
22a	22b (Signature)

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

CAUSE OF DEATH

23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)

PART I
(a) Respiratory Arrest — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF
(b) Adeno CA of lung — Interval between onset and death 1 yr.
DUE TO, OR AS A CONSEQUENCE OF
(c) Recurrent Deep Venous thrombosis. Peripheral Vascular Disease — Interval between onset and death 30 months

PART II OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I (a)
Organic Heart disease Chronic renal insufficiency

AUTOPSY (Specify Yes or No)	WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No)
24 NO	25 NO

ACCIDENT (Specify Yes or No)	DATE OF INJURY (Mo., Day, Year)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED
26a	26b	26c M	26d

INJURY AT WORK (Specify Yes or No)	PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	LOCATION STREET OR R.F.D. NO	CITY OR TOWN	STATE
26e	26f	26g		

DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES ☐ NO ☐ N/A ☒

WAS GIFT MADE? YES ☐ NO ☐ N/A ☒

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