

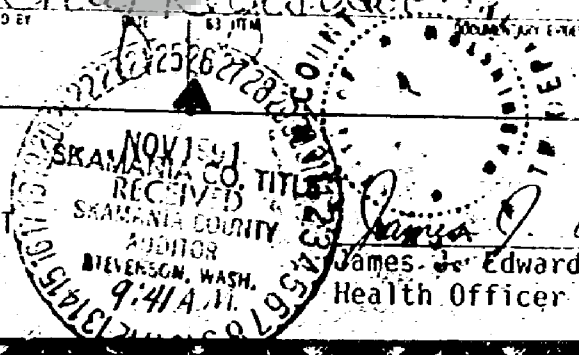
**STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF HEALTH**

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
VITAL RECORDS
112504 CERTIFICATE OF DEATH BOOK 126 PAGE 284

1 NAME - FIRST, MIDDLE, LAST LEONA A. ERICSON		2 SEX F		3 DEATH DATE (Mo., Day, Yr.) DEC. 5, 1988		4 LOCAL FILE NUMBER 288		5 STATE FILE NUMBER 146-8	
4 AGE - LAST BIRTH DAY (Mo., Day, Yr.) 86		5 UNDER 1 YEAR MOS. DAYS HOURS MINS		6 UNDER 1 YEAR MOS. DAYS HOURS MINS		7 BIRTH DATE (Mo., Day, Yr.) MARCH 3, 1902		8 COUNTY OF DEATH OKANOGAN	
9 CITY, TOWN OR LOCATION OF DEATH BREWSTER		10 PLACE OF DEATH - <input checked="" type="checkbox"/> HOME <input type="checkbox"/> IN TRANSPORT <input type="checkbox"/> EMERGENCY SERVICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER PLACE OKANOGAN-DOUGLAS COUNTY HOSPITAL		11 BIRTH STATE (if not in USA give country) MINNESOTA		12 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOWED		13 HOUSE (if wife give Marital Surname) HOWARD ERICSON	
17 USUAL OCCUPATION (Give kind of work done during most of working life or if retired) REGISTERED NURSE		18 KIND OF BUSINESS OR INDUSTRY MEDICAL		19 RACE (White, Black, Am. Ind., etc. Specify) WHITE		20 Was Excerpt of Hispanic Origin? (Specify Yes or No - if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (Specify)		21 SOCIAL SECURITY NO. [REDACTED]	
22 RESIDENCE - NUMBER AND STREET NO ERICSON TRACT RD.		23 CITY, TOWN OR LOCATION UNDERWOOD		24 INCL. CITY LIMITS (Yes/No) NO		25 COUNTY SKAMANIA		26 STATE WA	
27 ZIP CODE 98651		28 FATHER'S NAME - FIRST, MIDDLE, LAST EDWIN FOSS		29 MOTHER'S NAME - FIRST, MIDDLE, MAIDEN SURNAME HANNAH LUND		30 INFORMANT - NAME BETTY HAYES		31 MAILING ADDRESS - STREET OR RD. NO., CITY OR TOWN, STATE, ZIP BOX 973 BRIDGEPORT, WASHINGTON 98813	
32 BURIAL, CREMATION, REMOVAL, OTHER (Specify) BURIAL		33 DATE (Mo., Day, Yr.) DEC. 10, 1988		34 CEMETERY, CREMATORIUM - NAME FOREST LAWN MEMORIAL CEM.		35 LOCATION - CITY/TOWN, STATE GRESHAM, OREGON		36 FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	
37 NAME OF FACILITY BARNES CHAPEL		38 ADDRESS OF FACILITY BREWSTER, WASHINGTON		39 TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, AND PLACE AND DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE <i>[Signature]</i> 45 DATE SIGNED (Mo., Day, Yr.) 12-5-88		40 TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER 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) STATED. SIGNATURE AND TITLE <i>[Signature]</i> 44 DATE SIGNED (Mo., Day, Yr.) 12-5-88		46 HOURS OF DEATH (24 Hrs.) 10:34 A.M.	
41 NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) DALE ROBERTSON M.D. 124 WEST INDIAN AVE. BREWSTER, WASHINGTON 98812		42 NAME AND ADDRESS OF CERTIFIER - PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)		43 PRONOUNCED DEAD (Mo., Day, Yr.) NO		47 HOUR PRONOUNCED DEAD (24 Hrs.)		48 REGISTERED <input checked="" type="checkbox"/> INDEXED <input checked="" type="checkbox"/> FILED <input checked="" type="checkbox"/> MAILED	
49 PART I - ENTER THE DISEASES, INJURIES OR COMPLICATIONS WHICH CAUSED THE DEATH. DO NOT ENTER THE MANNER OF DYING, SUCH AS FATAL OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE IMMEDIATE CAUSE (Final disease or condition resulting in death). Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST. (1) Cardio respiratory arrest DUE TO OR AS A CONSEQUENCE OF (2) acute CHA DUE TO OR AS A CONSEQUENCE OF ASVD		50 OTHER SIGNIFICANT CONDITIONS - CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN ABOVE ASVD		51 A. POST-MORTEM NO		52 INTERVAL BETWEEN ONSET AND DEATH 7-8 hrs		53 INTERVAL BETWEEN ONSET AND DEATH 12 hr	
54 INC. SURVEY HOW INJURY OCCURRED (Specify) NO		55 HOURS OF INJURY (24 Hrs.)		56 DESCRIBE HOW INJURY OCCURRED		57 WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No) NO		58 DATE RECEIVED (Mo., Day, Yr.) 12-9-88	
59 INJURY AT HOME? (Yes/No)		60 PLACE OF INJURY - AT HOME, FARM, STREET, FACTORY, OFFICE, BLDG, ETC. (Specify)		61 LOCATION - STREET OR RD. NO., CITY/TOWN, STATE		62 REGISTERAR SIGNATURE <i>[Signature]</i>		63 DATE RECEIVED (Mo., Day, Yr.)	
64 ITEM		65 SIGNATURE AND TITLE Kathy Chase Chief Registrar		66 DATE RECEIVED (Mo., Day, Yr.)		67 ITEM		68 SIGNATURE AND TITLE James J. Edwards M.D. Health Officer	

DSHS 9-150 (Rev. 1-85) - 1107

OKANOGAN COUNTY HEALTH DISTRICT



James J. Edwards M.D.
Health Officer

DSHS 9-641A (11-85)

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