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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER 146

DECEDENT

1. NAME — FIRST MIDDLE LAST	2. SEX	3. DEATH DATE (Mo. Day Yr.)
Ralph Michael CORNWELL	Male	12-12-91

4. AGE LAST BIRTHDAY (Yrs.)	5. UNDER 1 YEAR MOS / DAYS	6. UNDER 1 DAY HOURS / MINS	7. BIRTHDATE (Mo. Day Yr.)	8. BIRTH STATE (If not in USA give country)	9. CITIZEN OF WHAT COUNTRY?	10. COUNTY OF DEATH
66			5-14-25	Iowa	USA	Clark

11. CITY, TOWN, OR LOCATION OF DEATH	12. PLACE OF DEATH — 1 BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME (1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG RM/OUT PTN 4 ☐ HOSP 5 ☐ NUR HOME 6 ☐ OTHER PLACE)	13. SMOKING IN LAST 15 YEARS? (Yes/No)
Vancouver	Southwest Washington Medical Center	Yes

14. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (If wife, give maiden name)	16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No)	17. SOCIAL SECURITY NO.	18. HIGH SCHOOL GRADUATE? (Yes/No)
Married	Marian Whitson	Yes	[redacted]	Yes

19. USUAL OCCUPATION (Give kind of work - Some during most of working life. DO NOT USE RETIRED)	20. KIND OF BUSINESS OR INDUSTRY	21. Was Decedent of Hispanic Origin or Descent? (Ancestry) (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No	22. RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc.) (Specify)
Pharmacist	Pharmacy		White

23. RESIDENCE - NUMBER AND STREET	24. CITY/TOWN, OR LOCATION	25. INSIDE CITY LIMITS? (Yes/No)	26. COUNTY	27. STATE	28. ZIP CODE
37 Lakeshore Drive	Skamania	No	Skamania	Washington	98648

PARENTS

29. FATHER'S NAME — FIRST MIDDLE LAST	30. MOTHER'S NAME — FIRST, MIDDLE, MAIDEN SURNAME
John J. Cornwell	Mary R. Hosman

31. INFORMANT — NAME	32. MAILING ADDRESS — STREET OR RFD NO. / CITY OR TOWN / STATE / ZIP
Kevin Cornwell	327 N. 84th Street, Seattle, WA 98103

DISPOSITION

33. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34. DATE (Mo. Day Yr.)	35. CEMETERY/CREMATORY — NAME	36. LOCATION — CITY, TOWN, STATE
Burial	12-16-91	Stevenson Cemetery	Stevenson, Washington

37. FUNERAL DIRECTOR SIGNATURE	38. NAME OF FACILITY	39. ADDRESS OF FACILITY
X Marjorie C. Hay	Corinthian Funeral Service	11667 S.E. Stevens Road Portland, Oregon 97266

CAUSE OF DEATH

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

40. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED

SIGNATURE AND TITLE X

42. DATE SIGNED (Mo. Day Yr.)	43. HOUR OF DEATH (24 Hrs.)
12/13/91	2:45 a.m.

44. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
F.D. PRONO MD.

45. NAME AND ADDRESS OF CERTIFIER — PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)
315 SE Stonemill Dr. #110 VANCOUVER, WA 98664

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

41. 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 X

46. DATE SIGNED (Mo. Day Yr.)	47. HOUR OF DEATH (24 Hrs.)

47. PRONOUNCED DEAD (Mo. Day Yr.)	48. HOUR PRONOUNCED DEAD (24 Hrs.)

50. PART I. ENTER THE DISEASES, INJURIES OR COMPLICATIONS WHICH CAUSED THE DEATH. DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE.

		INTERVAL BETWEEN ONSET AND DEATH
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	(a) Hypoxia	[redacted] minutes
	DUE TO OR AS A CONSEQUENCE OF (b) Respiratory and cardiovascular collapse	5 days
	DUE TO OR AS A CONSEQUENCE OF (c) Carcinoma of lung	8 months

51. OTHER SIGNIFICANT CONDITIONS — CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE	52. AUTOPSY? (Yes/No)	53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No)
	no	no

54. ACC., SUICIDE, HO, UNDET., OR PENDING INVEST. (Specify)	55. INJURY DATE (Mo. Day Yr.)	56. HOUR OF INJURY (24 Hrs.)	57. DESCRIBE HOW INJURY OCCURRED

58. INJURY AT WORK? (Yes/No)	59. PLACE OF INJURY — AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (Specify)	60. LOCATION — STREET OR RFD NO., CITY/TOWN, STATE

61. REGISTRAR SIGNATURE X Karen Steingart, MD.

62. DATE RECEIVED (Mo. Day Yr.) DEC 13 1991

DOH 110-008 (Rev. 8/89) (formerly OSHS 9-150)

SOUTHWEST WASHINGTON HEALTH DISTRICT SEAL

DEC 13 1991

Registered
Indexed, Dir
Indirect
Filmed 1/22/92
Mailed

Karen Steingart, MD.

Karen Steingart, M.D.
Public Health District Officer

DOH 01-003 (7/89)

JAN 7 1992 RECEIVED SKAMANIA COUNTY AUDITOR STEVENSON, WASH 8:55 AM

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