

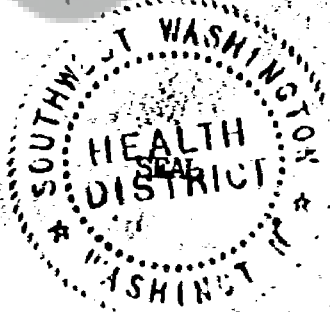
STATE OF WASHINGTON
DEPARTMENT OF HEALTH

LOCAL FILE NUMBER

CERTIFICATE OF DEATH

1 NAME - FIRST MIDDLE LAST Ralph Michael CORNWELL				2 SEX Male		3 DEATH DATE (Mo. Day Yr.) 12-12-91		146		STATE FILE NUMBER			
4 AGE LAST BIRTH DAY (Yr.) 66		5 UNDER 1 YEAR MOS DAYS		6 UNDER 1 DAY HOURS MINS		7 BIRTH DATE (Mo. Day Yr.) 5-14-25		8 BIRTH STATE (If not in USA give country) Iowa		9 CITIZEN OF WHAT COUNTRY? USA		10 COUNTY OF DEATH Clark	
11 CITY/TOWN OR LOCATION OF DEATH Vancouver				12 PLACE OF DEATH - BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME (1) HOME (2) IN TRANSPORT (3) EMERGENCY ROOM (4) HOSPITAL (5) NURSING HOME (6) OTHER PLACE Southwest Washington Medical Center				13 SURVIVING AT LAST 15 YEARS (Yr. Mo. Day) Yes					
14 MARITAL STATUS - Married Never Married Widowed Divorced (Specify)		15 SURVIVING SPOUSE (If wife give maiden name) Marian Whitson				16 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yr. Mo. Day) Yes		17 SOCIAL SECURITY NO. [REDACTED]		18 HIGH SCHOOL GRADUATE? (Yr. Mo. Day) Yes			
19 USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) Pharmacist		20 KIND OF BUSINESS OR INDUSTRY Pharmacy		21 WAS DECEDENT OF Hispanic Origin or descent? (Ancestry) (Specify Yes or No) If Yes specify Cuban, Mexican, Puerto Rican, etc. No		22 RACE (White, Black, Asian or Pacific Islander, Am. Ind. Hawaiian, etc. Specify) White							
23 RESIDENCE - NUMBER AND STREET 37 Lakeshore Drive				24 CITY/TOWN OR LOCATION Skamania		25 INSIDE CITY LIMITS? (Yr. Mo. Day) No		26 COUNTY Skamania		27 STATE Washington		28 ZIP CODE 98648	
29 FATHER'S NAME - FIRST MIDDLE LAST John J. Cornwell						30 MOTHER'S NAME - FIRST MIDDLE MAIDEN SURNAME Mary R. Hosman							
31 INFORMANT - NAME Kevin Cornwell				32 MAILING ADDRESS 327 N. 84th Street, Seattle, WA 98103									
33 BURIAL CREMATION REMOVAL OTHER (Specify) Burial		34 DATE (Mo. Day Yr.) 12-16-91		35 CEMETERY/CREMATORY - NAME Stevenson Cemetery				36 LOCATION - CITY/TOWN STATE Stevenson, Washington					
37 FUNERAL DIRECTOR Signature: <i>Therapies</i>		38 NAME OF FACILITY Corinthian Funeral Service				39 ADDRESS OF FACILITY 11667 S.E. Stevens Road Portland, Oregon 97266							
40 TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN						41 TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER							
42 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 <i>[Signature]</i>						43 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							
44 DATE SIGNED (Mo. Day Yr.) 12/13/91		45 HOUR OF DEATH (On Hrs.) 2:45 a.m.		46 DATE SIGNED (Mo. Day Yr.)		47 HOUR OF DEATH (On Hrs.)							
48 NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) F D PROANO MD.				49 PHONED DEAD (Mo. Day Yr.)		50 HOUR PHONED DEAD (On Hrs.)							
51 NAME AND ADDRESS OF CERTIFIER - PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) 315 SE. STORMILL DR. #110 VANCOUVER, WA 98684													
52 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.													
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.				53 DUE TO OR AS A CONSEQUENCE OF a Hypoxia b Respiratory and cardiovascular collapse c Carcinoma of lung				INTERVAL BETWEEN ONSET AND DEATH 10 min 5 days 8 months					
54 ACC. SUICIDE, HO. UNDET. OR PENDING INVEST (Specify)				55 INJURY DATE (Mo. Day Yr.)		56 HOUR OF INJURY (On Hrs.)		57 DESCRIBE HOW INJURY OCCURRED		58 AUTOPSY? (Yr. Mo. Day) No		59 THIS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yr. Mo. Day) No	
58 INJURY AT WORK? (Yr. Mo. Day)		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 <i>Karen Steingart, M.D.</i>						62 DATE RECEIVED (Mo. Day Yr.) DEC 13 1991							

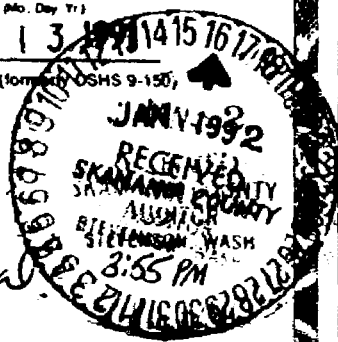
DOH 110-008 (Rev. 8/88) (Form for USHS 9-150)



DEC 13 1991

Registered
Indexed, Dir
Indirect
Filed 1/22/92
MailedKaren Steingart, M.D.
Public Health District Officer

DOH 01-003 (7.89)



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