STATE OF WASHINGTON DEPARTMENT OF HEALTH

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113332 STATE OF WASHINGTON DEPARTMENT OF HEALTH VITAL RECORDS

BOOK 128 PAGE 285

LOCAL FILE NUMBER

CERTIFICATE OF DEATH

STATE FILE NUMBER 146

DECEDENT

1. NAME—FIRST MIDDLE LAST: Jane --- MAGUIRE	2. SEX: Female	3. DEATH DATE (Mo. Day Yr.): 02 Mar 1990				
4. AGE LAST BIRTHDAY (Yrs): 39	5. UNDER 1 YEAR: MOS. DAYS	6. UNDER 1 DAY: HOURS MINS.	7. BIRTHDATE (Mo. Day Yr.): 2/9/1951	8. BIRTH STATE (If not in USA give country): New Mexico	9. CITIZEN OF WHAT COUNTRY: U.S.A.	10. COUNTY OF DEATH: Klickitat
11. CITY, TOWN OR LOCATION OF DEATH: White Salmon	12. PLACE OF DEATH — BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTE IN NAME: 1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG ROOM OUT PTN 4 ☒ HOSP 5 ☐ NUR HOME 6 ☐ OTHER PLACE: Skyline Hospital				13. SMOKING IN LAST 15 YEARS? (Yes/No): No	
14. MARITAL STATUS — Married, Never Married, Widowed, Divorced: Married	15. SURVIVING SPOUSE (If wife give maiden name): Jerry - Maguire	16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No): No	17. SOCIAL SECURITY NO: [redacted]	18. HIGH SCHOOL GRADUATE? (Yes/No): Yes		
19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED): Clerk	20. KIND OF BUSINESS OR INDUSTRY: Food Market	21. WAS DECEDENT OF HISPANIC ORIGIN OR DESCENT? (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No	22. RACE (White, Black, Asian, Pacific Islander, Am. Ind., Hispanic, etc.): White			
23. RESIDENCE - NUMBER AND STREET: Lot 11 Vine Maple Loop	24. CITY, TOWN OR LOCATION: Carson	25. INSIDE CITY LIMITS? (Yes/No): No	26. COUNTY: Skamania	27. STATE: Washington	28. ZIP CODE: 98610	

PARENTS

29. FATHER'S NAME—FIRST MIDDLE LAST: Dawl - Rackley	30. MOTHER'S NAME—FIRST MIDDLE MAIDEN SURNAME: Norma - Hudgens

INFORMANT

31. INFORMANT—NAME: Janice Wilson	32. MAILING ADDRESS (STREET OR RFD NO., CITY OR TOWN, STATE, ZIP): P.O. Box 145 Stevenson, WA 98648

DISPOSITION

33. BURIAL, CREMATION, REMOVAL, OTHER (Specify): Burial	34. DATE (Mo. Day Yr.): 3/7/90	35. CEMETERY, CREMATORY—NAME: Wind River Cemetery	36. LOCATION—CITY, TOWN, STATE: Carson, WA
37. FUNERAL DIRECTOR SIGNATURE: X K. L. Dierick		38. NAME OF FACILITY: GARDNER FUNERAL HOME, INC.	39. ADDRESS OF FACILITY: Box 390 White Salmon, WA 98672

CERTIFIER

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 David Hindahl MD

42. DATE SIGNED (Mo. Day Yr.): 3-5-90

43. HOUR OF DEATH (24 Hrs.): 0902

44. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):

45. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): David Hindahl, M.D. P.O. Box 1519 White Salmon, WA 98672

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

44. DATE SIGNED (Mo. Day Yr.):

45. HOUR OF DEATH (24 Hrs.):

47. PRONOUNCED DEAD (Mo. Day Yr.):

48. HOUR PRONOUNCED DEAD (24 Hrs.):

CAUSE OF DEATH

49. 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	(a) Cardiopulmonary arrest	INTERVAL BETWEEN ONSET AND DEATH: Approximately 1 hr
	DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary embolus (Thromboembolus)	INTERVAL BETWEEN ONSET AND DEATH: " "
	DUE TO, OR AS A CONSEQUENCE OF (c)	INTERVAL BETWEEN ONSET AND DEATH

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

Karen Steingart, MD

61. DATE RECEIVED (Mo. Day Yr.): 03-06-90

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

SEAL

Karen Steingart, MD

KAREN R. STEINGART, M.D.

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DOH 01-003 (7/89)

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SKAMANIA CO. WASH
BY Jerry Maguire
APR 21 2 40 PM '92
AUDITOR
GARY M. OLSON