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

VITAL RECORDS

13 LOCAL FILE NUMBER 113571 **CERTIFICATE OF DEATH** BOOK 128 PAGE 782

146 STATE FILE NUMBER

DECEDENT

1 NAME – FIRST MIDDLE LAST	2 SEX	3 DEATH DATE (Mo. Day. Yr.)
Lynnetta G. MORNINGSTAR	Female	06 Jun 1989

4 AGE LAST BIRTH DAY (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
45			11/6/1943	Washington	U.S.A.	Skamania

11 CITY, TOWN OR LOCATION OF DEATH	12 PLACE OF DEATH – BE BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME	13 SMOKING IN LAST 15 YEARS? (Yes/No)
Stevenson	X 1 HOME 2 DOA HANSPORT 3 EMERG ROOM/OUTPT 4 HOSP 5 NURS HOME 6 OTHER PLACE 270 Columbia View Avenue	No

14 MARITAL STATUS – Married, Never Married, Widowed, Divorced	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	Gary W. Morningstar	NO	[redacted]	Yes

19 USUAL OCCUPATION (Give kind of work done 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 X 2 No	22 RACE – (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc.) (Specify)
Teacher	Education		White

23 RESIDENCE – NUMBER AND STREET	24 CITY, TOWN OR LOCATION	25 INSIDE CITY LIMITS? (Yes/No)	26 COUNTY	27 STATE	28 ZIP CODE
270 Columbia View Ave	Stevenson	Yes	Skamania	Washington	98648

PARENTS

29 FATHER'S NAME – FIRST MIDDLE LAST	30 MOTHER'S NAME – FIRST MIDDLE MAIDEN SURNAME
Gilbert A. Giles	Helen – Hawthorne

INFORMANT

31 INFORMANT – NAME	32 MAILING ADDRESS (STREET OR RFD NO. CITY OR TOWN STATE ZIP)
Gary W. Morningstar	P.O. Box 386 Stevenson, WA 98648

DISPOSITION

33 BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34 DATE (Mo. Day. Yr.)	35 CEMETERY/CREMATORY – NAME	36 LOCATION – CITY/TOWN, STATE
Cremation	6/8/89	Park Hill Crematory	Vancouver, WA

37 FUNERAL DIRECTOR SIGNATURE	38 NAME OF FACILITY	39 ADDRESS OF FACILITY
X R. L. Davis	GARDNER FUNERAL HOME, INC.	Box 390 White Salmon, WA 98672

MEDICAL CERTIFICATION

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.)

45 NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

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 Robert K Leick

44 DATE SIGNED (Mo. Day. Yr.) June 12, 1989

45 HOUR OF DEATH (24 Hrs.) 0130

46 DATE PRONOUNCED DEAD (Mo. Day. Yr.) June 06, 1989

46 HOUR PRONOUNCED DEAD (24 Hrs.) 0600

48 NAME AND ADDRESS OF CERTIFIER – PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)
Robert K. Leick, Coroner Skamania County Courthouse Stevenson, WA

CAUSE OF DEATH

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

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)	Respiratory Failure	
	DUE TO, OR AS A CONSEQUENCE OF: (b)	Medi-static Carcinoma of Breast	2 Yrs.
	DUE TO, OR AS A CONSEQUENCE OF: (c)		

51 OTHER SIGNIFICANT CONDITIONS – CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE

52 AUTOPSY? (Yes/No) No

53 WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No) Yes

INJURY

54 ACC, SUICIDE, HOMICIDE, 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 M.D.

62 DATE RECEIVED (Mo. Day. Yr.) June 13, 1989

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SOUTHWEST WASHINGTON HEALTH DISTRICT
Karen Steingart, M.D.
Karen R. Steingart, M.D.
District Health Officer

SOUTHWEST WASHINGTON HEALTH DISTRICT ★ SEAL ★ WASHINGTON
JUN 13 1989

DSHS 9-641A (11 85)

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1