114671

BOOK 131 PAGE 351

LF 815

CF

STATE OF MICHIGAN
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER
0453394

TYPE; PRINT IN PERMANENT BLACK INK

NAME OF DECEDENT FOR USE BY PHYSICIAN OR INSTITUTION

ENT

1 DECEDENT'S NAME (First, Middle, Last)			2 SEX	3 DATE OF DEATH (Month, Day, Year)
Leta	R.	Gust	female	Oct. 29, 1991

4a AGE - Last Birthday (Years)	4b UNDER 1 YEAR: MONTHS	DAYS	4c UNDER 1 DAY: HOURS	MINUTES	5 DATE OF BIRTH (Month, Day, Year)	6 COUNTY OF DEATH
89					April 2, 1902	Bay

7a LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c) HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)	7b If HOSP. OR INST., Inpatient, Op./Emer. Room, DOA (Specify)	7c CITY, VILLAGE, OR TOWNSHIP OF DEATH
Bay Medical Center	inpatient	Bay City

8 SOCIAL SECURITY NUMBER	9a USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	9b KIND OF BUSINESS OR INDUSTRY
[redacted]	Bookkeeper	Insurance Co.

10a CURRENT RESIDENCE - STATE	10b COUNTY	10c LOCALITY (Check one box and specify)	10d STREET AND NUMBER
MI	Bay	☒ INSIDE CITY OR VILLAGE OF Bay City ☐ TWP. OF	423 Nebobish

10e ZIP CODE	11 BIRTHPLACE (City and State or Foreign Country)	12 MARITAL STATUS - Married, never married, Widowed, Divorced (Specify)	13 SURVIVING SPOUSE (If wife, give name before first married)	14 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
48708	Bay City, MI	Widowed	none	no

15 ANCESTRY - Mexican, Puerto Rican, Cuban, Central or South American, Chicano, other Hispanic, Afro-American, Arab, English, French, Finnish, etc (Specify below)	16 RACE - American Indian, Black, White, etc If Asian, give nationality i.e., Chinese, Filipino, Asian Indian, etc (Specify below)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
		Elementary/Secondary (0-12)	College (1-4 or 5+)
Scottish	White	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Surname before first married)
John H. Reid	Anna Mae Metevia

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, ZIP Code)
Maxine Jones	515 Nebobish Bay City, MI 48708

21 METHOD OF DISPOSITION - Burial, Cremation, Removal, Donation, Other (Specify)	22a PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place)	22b LOCATION - City or Village, State
Burial	Elm Lawn Cemetery	Bay City, MI

HON

23 SIGNATURE OF FUNERAL SERVICE LICENSEE	24 LICENSE NUMBER (of Licensee)	25 NAME AND ADDRESS OF FACILITY
Kurt A. Stackus	6101	PENZIEN & STEELE FUNERAL HOME 608 N. Madison Ave. BAY CITY, MI 48708

CAUSE OF DEATH

26 PART I Enter the diseases, injuries, or complications that 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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition → resulting in death)	a Ruptured abdominal aortic aneurysm	6 hours
Sequentially list conditions, IF ANY, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b DUE TO (OR AS A CONSEQUENCE OF)	
	c DUE TO (OR AS A CONSEQUENCE OF)	
	d DUE TO (OR AS A CONSEQUENCE OF)	

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

27a WAS AN AUTOPSY PERFORMED? (Yes or No)	27b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
no	

28 ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) (Specify)	29 WAS CASE REFERRED TO MEDICAL EXAMINER? (Specify Yes or No)
Hospital	no

CERTIFYING PHYSICIAN

30a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) David C. Reyes MD

30b DATE SIGNED (Mo., Day, Yr.)	30c TIME OF DEATH
10-29-91	5:43 A M

30d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

MEDICAL EXAMINER

31a (Check one only) ☐ The case reviewed and determined not to be a medical examiner's case. ☐ On the basis of examination and of investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated. (Signature and Title)

31b DATE SIGNED (Mo., Day, Yr.)	31c CASE NUMBER

31d PRONOUNCED DEAD (Mo., Day, Yr.)	31e TIME OF DEATH
ON	M

32a NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type or Print): David C. Reyes, M.D. 2110 16th St. Bay City, MI 48708

32b LICENSE NUMBER: 31875

MEDICAL EXAMINER

33a ACC. SUICIDE, HOM., NATURAL OR PENDING INVEST. (Specify)	33b DATE OF INJURY (Mo., Day, Yr.)	33c TIME OF INJURY	33d DESCRIBE HOW INJURY OCCURRED
natural		- M	

33e INJURY AT WORK (Specify Yes or No)	33f PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	33g LOCATION - Street or R.F.D. No. City, Village or Twp. State

B-38
Rev. 1/90

34a REGISTRAR'S SIGNATURE: Barbara Albertson

34b DATE FILED (Month, Day, Year): October 31, 1991

FILED FOR RECORD
SKAMANIA CO WASH
BY SKAMANIA CO. TITLE

OCT 13 2 33 PM '92
P. Lowry
AUDITOR
GARY M. OLSON

STATE OF MICHIGAN
County
City, Michigan

CERTIFIED COPY OF RECORD

I, BARBARA ALBERTSON, Clerk of the County of Bay, and of the Circuit Court thereof, the same being a Court of Record having a Seal, do hereby certify that the following is a true copy of [illegible] remaining in my office, and of the whole thereof, viz:

In Testimony Whereof, I have hereunto set my hand and affixed the seal of said Circuit Court this [illegible] day of SEPTEMBER A.D. 19 92

BARBARA ALBERTSON, County Clerk

REAL ESTATE EXCISE TAX

OCT 13 1992

Registered
Indexed, Dir
Indirect
Filmed 10/20/92
Mailed

C15308 PAID Exempt

Deputy

SKAMANIA COUNTY TREASURER