STATE OF WASHINGTON
DEPARTMENT OF HEALTH

STATE OF WASHINGTON DEPARTMENT OF HEALTH
VITAL RECORDS

LOCAL FILE NUMBER 11

CERTIFICATE OF DEATH

BOOK 124 PAGE 8

STATE FILE NUMBER 146

DECEDENT

1. NAME—FIRST, MIDDLE, LAST: Grace Elizabeth QUOSS
2. SEX: Female
3. DEATH DATE (Mo., Day, Yr.): 6/29/1991
4. AGE LAST BIRTHDAY (Yrs): 72
5. UNDER 1 YEAR (MOS. DAYS):
6. UNDER 1 DAY (HOURS MINS):
7. BIRTHDATE (Mo., Day, Yr.): 7/28/1918
8. BIRTH STATE (if not in USA give country): Oklahoma
9. CITIZEN OF WHAT COUNTRY?: U.S.A.
10. COUNTY OF DEATH: Skamania
11. CITY, TOWN OR LOCATION OF DEATH: Carson
12. PLACE OF DEATH — ☑ BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME: 1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG. RM/OUT PTN 4 ☐ HOSP. 5 ☐ NUR. HOME X ☐ OTHER PLACE: Boyer's Foster Home
13. SMOKING IN LAST 15 YEARS? (Yes/No): No
14. MARITAL STATUS — Married, Never Married, Widow(er), Divorced (Specify): Married
15. SURVIVING SPOUSE (if wife, give maiden name): Walter C. Quoss
16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No): No
17. SOCIAL SECURITY NO.: 545-26-1768
18. HIGH SCHOOL GRADUATE? (Yes/No): 8
19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED): Homemaker
20. KIND OF BUSINESS OR INDUSTRY: Own Home
21. Was Decedent of Hispanic Origin or descent? (Ancestry) (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No
22. RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc.) (Specify): White
23. RESIDENCE - NUMBER AND STREET: Guide Meridian Road
24. CITY/TOWN, OR LOCATION: Stevenson
25. INSIDE CITY LIMITS? (Yes/No): No
26. COUNTY: Skamania
27. STATE: Washington
28. ZIP CODE: 98648

PARENTS

29. FATHER'S NAME—FIRST, MIDDLE, LAST: Valentine
30. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME: Annie McGee

31. INFORMANT—NAME: Walter Quoss
32. MAILING ADDRESS (STREET OR RFD NO., CITY OR TOWN, STATE, ZIP): P.O. Box 147 Stevenson, WA 98648

DISPOSITION

33. BURIAL, CREMATION, REMOVAL, OTHER (Specify): Burial
34. DATE (Mo. Day, Yr.): 7/2/1991
35. CEMETERY/CREMATORY—NAME: Wind River Cemetery
36. LOCATION—CITY/TOWN, STATE: Carson, WA
37. FUNERAL DIRECTOR SIGNATURE: X [signature]
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
42. DATE SIGNED (Mo., Day, Yr.)
43. HOUR OF DEATH (24 Hrs.)
46. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): Robert K. Leick, Coroner Skamania County Courthouse Stevenson, WA

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, PLACE AND DUE TO THE CAUSE(S) STATED
SIGNATURE AND TITLE: X [signature], Coroner
44. DATE SIGNED (Mo., Day, Yr.): July 3, 1991
45. HOUR OF DEATH (24 Hrs.): 1030
47. PRONOUNCED DEAD (Mo., Day, Yr.): June 29, 1991
48. HOUR PRONOUNCED DEAD (24 Hrs.): 1135

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) Creutzfeldt Jakob (Jakobs Disease) — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO, OR AS A CONSEQUENCE OF
(B) — 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): No
53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No): Yes
54. ACC., SUICIDE, HO., UNDET., OR PENDING INVEST. (Specify): Terminal Illness
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.): 7-3-91

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

JUL 3 1991 SOUTHWEST WASHINGTON HEALTH DISTRICT SEAL WASHINGTON

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

DOH 01-003 (7/89)

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