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

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
VITAL RECORDS

288 LOCAL FILE NUMBER 112504 **CERTIFICATE OF DEATH** BOOK 126 PAGE 284

146-8 STATE FILE NUMBER

DECEDENT

1 NAME – FIRST, MIDDLE, LAST: LEONA A. ERICSON
2 SEX: F
3 DEATH DATE (Mo., Day, Yr.): DEC. 5, 1988
4 AGE – LAST BIRTHDAY (Yrs.): 86
5 UNDER 1 YEAR – MOS / DAYS
6 UNDER 1 DAY – HOURS / MINS
BIRTHDATE (Mo., Day, Yr.): MARCH 3, 1902
8 COUNTY OF DEATH: OKANOGAN
9 CITY, TOWN OR LOCATION OF DEATH: BREWSTER
10 PLACE OF DEATH – 20 BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME: 1 [ ] HOME 2 [ ] IN TRANSPORT 3 [ ] EMERG RM/OUT PTN 4 [X] HOSP 5 [ ] NURS HOME 6 [ ] OTHER PLACE: OKANOGAN-DOUGLAS COUNTY HOSPITAL
11. BIRTH STATE (If not in USA give country): MINNESOTA
12 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED: WIDOWED
13 SPOUSE (If Wife give Maiden Surname): HOWARD ERICSON
14 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No): NO
15 SOCIAL SECURITY NO: 537-30-7271
16. HIGH SCHOOL GRADUATE (Yes/No): YES
17 USUAL OCCUPATION (Give kind of work done during most of working life even if retired): REGISTERED NURSE
18 KIND OF BUSINESS OR INDUSTRY: MEDICAL
19 RACE (White, Black, Am. Ind., etc. Specify): WHITE
20 Was Decedent of Hispanic Origin? (specify Yes or No – if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. [ ] Yes 2. [X] No (specify)
21 SMOKING IN LAST 15 YEARS (Yes/No): NO
22 RESIDENCE – NUMBER AND STREET: ERICSON TRACT RD.
23 CITY, TOWN, OR LOCATION: UNDERWOOD
24 INSIDE CITY LIMITS? (Yes/No): NO
25 COUNTY: SKAMANIA
26 STATE: WA
27 ZIP CODE: 98651

PARENTS

28 FATHER'S NAME – FIRST, MIDDLE, LAST: EDWIN FOSS
29 MOTHER'S NAME – FIRST, MIDDLE, MAIDEN SURNAME: HANNAH LUND

DISPOSITION

30 INFORMANT – NAME: BETTY HAYES
31. MAILING ADDRESS – STREET OR RFD NO / CITY OR TOWN / STATE / ZIP: BOX 973 BRIDGEPORT, WASHINGTON 98813
32 BURIAL, CREMATION, REMOVAL, OTHER (Specify): BURIAL
33 DATE (Mo., Day, Yr.): DEC. 10. 1988
34 CEMETERY/CREMATORY – NAME: FOREST LAWN MEMORIAL CEM
35 LOCATION – CITY/TOWN, STATE: GRESHAM, OREGON
36 FUNERAL DIRECTOR – SIGNATURE: X [signature]
37 NAME OF FACILITY: BARNES CHAPEL
38 ADDRESS OF FACILITY: BREWSTER, WASHINGTON

CERTIFIER

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

39 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 [signature] MD
40 DATE SIGNED (Mo., Day, Yr.): 12-5-88
41 HOUR OF DEATH (24 Hrs.): 10:34 A.M.
42 NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
48 NAME AND ADDRESS OF CERTIFIER – PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): DALE ROBERTON M.D. 124 WEST INDIAN AVE. BREWSTER, WASHINGTON 98812

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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.)
45 HOUR OF DEATH (24 Hrs.)
46 PRONOUNCED DEAD (Mo., Day, Yr.)
47 HOUR PRONOUNCED DEAD (24 Hrs.)

Registered
Indexed, dir
Indirect
Filmed 11/27/89
Mailed

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) Cardio respiratory arrest — INTERVAL BETWEEN ONSET AND DEATH: 2-5 min
DUE TO, OR AS A CONSEQUENCE OF
(B) acute CVA. — INTERVAL BETWEEN ONSET AND DEATH: 12 hr.
DUE TO OR AS A CONSEQUENCE OF
(C) CVA. — INTERVAL BETWEEN ONSET AND DEATH: yrs.

50 OTHER SIGNIFICANT CONDITIONS – CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN ABOVE
51 AUTOPSY (Yes/No): NO
52 WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Yes/No): NO
53 ACC, SUICIDE, HOM, UNDET, OR PENDING INVEST (Specify)
54 INJURY DATE (Mo., Day, Yr.)
55 HOUR OF INJURY (24 Hrs.)
56 DESCRIBE HOW INJURY OCCURRED
57 INJURY AT WORK? (Yes/No)
58 PLACE OF INJURY – AT HOME, FARM, STREET, FACTORY, OFFICE BLDG, ETC. (Specify)
59 LOCATION – STREET OR RFD NO, CITY/TOWN, STATE

60 REGISTRAR SIGNATURE: X Kathy Chase Chief Registration Clerk
61 DATE RECEIVED (Mo., Day, Yr.): 12-9-88

FOR STATE REGISTRAR USE ONLY

62 ITEM	DOCUMENTARY EVIDENCE	REVIEWED BY	DATE	63 ITEM	DOCUMENTARY EVIDENCE	REVIEWED BY	DATE

DSHS 9-150 (Rev 1-88) -1187-

OKANOGAN COUNTY HEALTH DISTRICT

SKAMANIA CO. TITLE
RECEIVED
NOV 1991
SKAMANIA COUNTY
AUDITOR
STEVENSON, WASH.
9:41 A.M.

James O. Edwards M.D.
James O. Edwards, M.D.
Health Officer

DSHS 9-641A (11-88)

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