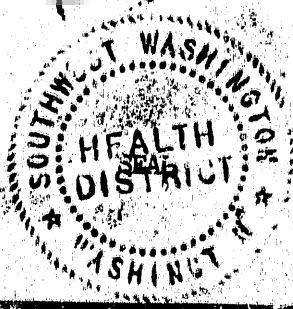


STATE OF WASHINGTON
DEPARTMENT OF HEALTH

LOCAL FILE NUMBER

CERTIFICATE OF DEATH

1 NAME—FIRST, MIDDLE, LAST Ralph Michael CORNWELL				2 SEX Male		3 DEATH DATE (Mo., Day, Yr.) 12-12-91		146			
4 AGE LAST BIRTHDAY (Yrs) 66		5 UNDER 1 YEAR MOS. DAYS 5-14-25		7 BIRTHDATE (Mo., Day, Yr.) 5-14-25		8 BIRTH STATE (If not in USA give country) Iowa		9 CITIZEN OF U.S. (Country) USA		13 COUNTY OF DEATH Clark	
11 CITY, TOWN OR LOCATION OF DEATH Vancouver				12 PLACE OF DEATH — IN BOX FOR PLACE THEN GIVE ADDRESS OF INSTITUTION NAME Southwest Washington Medical Center				13 SMOKING IN LAST 15 YEARS? (Yes/No) Yes			
14 MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) Married		15 SURVIVING SPOUSE (If alive, give maiden name) Marian Whitson				16 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No) Yes		17 SOCIAL SECURITY NO. 478-24-2593		18 HIGH SCHOOL GRADUATE? (Yes/No) Yes	
19 USUAL OCCUPATION (Give kind of work done during most of working life DO NOT USE RETIRED) Pharmacist		20 KIND OF BUSINESS OR INDUSTRY Pharmacy		21 Was Decedent of Hispanic Origin or descent? (Ancestry) (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) No		22 RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc.) (Specify) White					
23 RESIDENCE — NUMBER AND STREET 37 Lakeshore Drive				24 CITY, TOWN OR LOCATION Skamania		25 INSIDE CITY LIMITS? (Yes/No) No		26 COUNTY Skamania		27 STATE Washington	
28 FATHER'S NAME—FIRST, MIDDLE, LAST John J. Cornwell				29 MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME Mary R. Hosman							
31 INFORMANT—NAME Kevin Cornwell				32 MAILING ADDRESS 327 N. 84th Street, Seattle, WA 98103							
33 BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		34 DATE (Mo., Day, Yr.) 12-16-91		35 CEMETERY/CREMATORY—NAME Stevenson Cemetery		36 LOCATION—CITY/TOWN, STATE Stevenson, Washington					
37 SIGNATURE OF REGISTRAR <i>[Signature]</i>		38 NAME OF FACILITY Corinthian Funeral Service				39 ADDRESS OF FACILITY 11667 S.E. Stevens Road Portland, Oregon 97266					
40 TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN						41 TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER					
42 DATE SIGNED (Mo., Day, Yr.) 12/13/91						43 HOUR OF DEATH (24 Hrs.) 2:45 a.m.					
44 NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) ED PROANO MD						45 HOUR OF DEATH (24 Hrs.)					
46 NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) 315 SE Stockhill Dr. #110 VANCOUVER, WA 98684						47 PRONOUNCED DEAD (Mo., Day, Yr.)					
48 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						49 OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE					
(a) Hypoxia						INTERVAL BETWEEN ONSET AND DEATH 10 min					
(b) Respiratory and cardiovascular collapse						INTERVAL BETWEEN ONSET AND DEATH 5 days					
(c) Cerebral anoxia						INTERVAL BETWEEN ONSET AND DEATH 8 months					
50 ACC. SUICIDE HO. UNDET. OR PENDING INVEST. (Specify)						51 INJURY DATE (Mo., Day, Yr.)					
52 INJURY AT WORK? (Yes/No)						53 PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE, BLDG., ETC. (Specify)					
54 INJURY AT WORK? (Yes/No)						55 LOCATION—STREET OR RFD NO., CITY/TOWN, STATE					
56 REGISTERAR SIGNATURE <i>[Signature]</i>						57 DATE RECEIVED (Mo., Day, Yr.) DEC 13 1991					



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Indirect
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Mailed

Karen Steingart, M.D.

Karen Steingart, M.D.
Public Health District Officer

