STATE OF WASHINGTON
DEPARTMENT OF HEALTH

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STATE OF WASHINGTON DEPARTMENT OF HEALTH
VITAL RECORDS

113332 LOCAL FILE NUMBER

BOOK 128 PAGE 285

CERTIFICATE OF DEATH

1. NAME—FIRST, MIDDLE, LAST: Jane MAGUIRE
2. SEX: Female
3. DEATH DATE (Mo., Day, Yr.): 02 Mar 1990
146 STATE FILE NUMBER
4. AGE LAST BIRTHDAY (Yrs): 39
5. UNDER 1 YEAR: MOS. DAYS
6. UNDER 1 DAY: HOURS MINS.
7. BIRTHDATE (Mo., Day, Yr.): 2/9/1951
8. BIRTH STATE (If not in USA give country): New Mexico
9. CITIZEN OF WHAT COUNTRY?: U.S.A.
10. COUNTY OF DEATH: Klickitat
11. CITY, TOWN OR LOCATION OF DEATH: White Salmon
12. PLACE OF DEATH — If BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME: 1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG RM/OUT PTN 4 ☒ HOSP 5 ☐ NURS HOME 6 ☐ OTHER PLACE: Skyline Hospital
13. SMOKING IN LAST 15 YEARS? (Yes/No): No
14. MARITAL STATUS — Married, Never Married, Widowed, Divorced: Married
15. SURVIVING SPOUSE (If wife, give maiden name): Jerry - Maguire
16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No): No
17. SOCIAL SECURITY NO: 585-36-7063
18. HIGH SCHOOL GRADUATE? (Yes/No): Yes
19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED): Clerk
20. KIND OF BUSINESS OR INDUSTRY: Food Market
21. Was Decedent of Hispanic Origin or descent? (Ancestry): (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No
22. RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc.) (Specify): White
23. RESIDENCE - NUMBER AND STREET: Lot 11 Vine Maple Loop
24. CITY/TOWN, OR LOCATION: Carson
25. INSIDE CITY LIMITS? (Yes/No): No
26. COUNTY: Skamania
27. STATE: Washington
28. ZIP CODE: 98610
29. FATHER'S NAME—FIRST, MIDDLE, LAST: Pawl - Rackley
30. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME: Norma - Hudgens
31. INFORMANT—NAME: Janice Wilson
32. MAILING ADDRESS (STREET OR RFD NO., CITY OR TOWN, STATE, ZIP): P.O. Box 145 Stevenson, WA 98648
33. BURIAL, CREMATION, REMOVAL, OTHER (Specify): Burial
34. DATE (Mo., Day, Yr.): 3/7/90
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

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 [signature] MD
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
42. DATE SIGNED (Mo., Day, Yr.): 3-5-90
43. HOUR OF DEATH (24 Hrs.): 0902
44. DATE SIGNED (Mo., Day, Yr.):
45. HOUR OF DEATH (24 Hrs.):
46. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):
47. PRONOUNCED DEAD (Mo., Day, Yr.):
48. HOUR PRONOUNCED DEAD (24 Hrs.):
49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): David Hindahl, M.D. P.O. Box 1519 White Salmon, WA 98672

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) Cardiopulmonary arrest — INTERVAL BETWEEN ONSET AND DEATH: Approximately
DUE TO, OR AS A CONSEQUENCE OF
(B) Pulmonary embolus (Thromboembolus) — 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): Yes
53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No): No
54. ACC., SUICIDE, HOM., UNDET., 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

REGISTRAR'S SIGNATURE: Karen Steingart, MD
62. DATE RECEIVED (Mo., Day, Yr.): 03-06-90

DOH 110-006 (Rev. 8/86) (formerly DSHS 9-150)

SOUTHERN REGIONAL HEALTH DISTRICT — SEAL

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DOH 01-003 (7/89)

Karen Steingart, MD
KAREN R. STEINGART, M.D.

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BY Jerry Maguire
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AUDITOR
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