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I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

BOOK 129 PAGE 930

1017-91
Local File Number

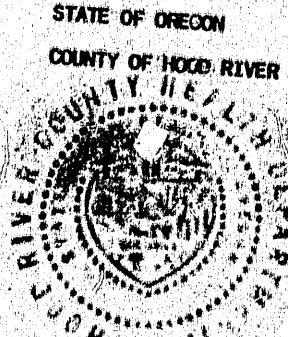
136

1. DECEDENT'S NAME First: Kermit Middle: R. Last: RUSSELL		2. SEX male	3. DATE OF DEATH (Month, Day, Year) Feb. 3, 1991
4. SOCIAL SECURITY NUMBER 534-28-1302	5a. AGE - Last Birthday (Year) 68	5b. Under 1 Year Mo. Days Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) Marion, OR
7. DATE OF BIRTH (Month, Day, Year) Aug. 24, 1902		8. PLACE OF DEATH (Check only one) ☐ Hospital ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☒ Other: Nursing Home	
9a. FACILITY NAME (If not institution, give street and number) Hood River Care Center		9b. CITY, TOWN, OR LOCATION OF DEATH Hood River	
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Foreman		10b. KIND OF BUSINESS/INDUSTRY State Highway Dept.	
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Mabel C.	
13a. RESIDENCE - STATE Washington		13b. COUNTY Skamania	
13c. CITY, TOWN, OR LOCATION Carson		13d. STREET AND NUMBER Box 178 Boyd Street	
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No		15. RACE American Indian, Black, White, etc. (Specify) White	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12)		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)	
18. FATHER - NAME first middle last Chester - Russell		19. MOTHER - NAME first middle maiden Della M. Rutherford	
20a. METHOD OF DISPOSITION ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Park Hill Crematory	
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>R. P. Dierckx</i>		21b. LICENSE NUMBER (Of Licensee) 1482	
22. DATE FILED (Month, Day, Year) FEB 07 1991		23. NAME, ADDRESS AND ZIP OF FACILITY GARDNER FUNERAL HOME, INC. Box 390 White Salmon, WA 98672	
24. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☐ YES ☐ NO ☒ N/A		25. WAS GIFT MADE? ☐ YES ☐ NO ☒ N/A	
TO BE COMPLETED BY CERTIFYING PHYSICIAN			
27. TIME OF DEATH 1415 M		28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes ☒ No	
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature) <i>J. Allan Henderson M.D.</i>			
30. DATE SIGNED (Month, Day, Year) 2-6-91			
31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) J. Allan Henderson, M.D. 11th & Jamie Hood River, OR 97031			
32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			
33. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.)			
(a) dissecting abdominal aortic aneurysm		Interval between onset and death 2 weeks	
(b) peripheral vascular disease		Interval between onset and death years	
(c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I. arteriosclerotic heart disease		Interval between onset and death	
34. MANNER OF DEATH ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Undetermined Manner ☐ Suicide ☐ Legal Intervention ☐ Homicide		35. DATE OF INJURY (Month, Day, Year)	
36. TIME OF INJURY		37. INJURY AT WORK? ☐ Yes ☒ No	
38. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		39. LOCATION (Street and Number, or other address, City or Town, State) SKAMANIA CO. WASH BY SKAMANIA CO. IIIA	

ORIGINAL - VITAL STATISTICS COPY

JUL 21 3 44 PM '92

GARY M. OLSON
COUNTY REGISTRAR OF VITAL STATISTICS



NOT VALID WITHOUT RAISED SEAL OF
HOOD RIVER COUNTY HEALTH DEPARTMENT

This certifies that the foregoing is a correct
and complete transcript of a record of death on
file with HOOD RIVER COUNTY PUBLIC HEALTH DEPARTMENT.

FEB 07 1991

DATE

Registered
Indexed, Dir
Indirect
Filed 8/6/92
Mailed