114671

BOOK 131 PAGE 351

LF 818

CF

STATE OF MICHIGAN
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER
0453394

TYPE/PRINT IN PERMANENT BLACK INK

NAME OF DECEDENT FOR USE BY PHYSICIAN OR INSTITUTION

1. DECEDENT'S NAME (First, Middle, Last)			2. SEX	3. DATE OF DEATH (Month, Day, Year)
Leta	R.	Gust	female	Oct. 29, 1991

4a. AGE – Last Birthday (Years)	4b. UNDER 1 YEAR MONTHS	4b. UNDER 1 YEAR DAYS	4c. UNDER 1 DAY HOURS	4c. UNDER 1 DAY MINUTES	5. DATE OF BIRTH (Month, Day, Year)	6. COUNTY OF DEATH
89					April 2, 1902	Bay

DECEDENT

7a. LOCATION OF DEATH (Enter place officially pronounced dead in 7a, 7b, 7c.) HOSPITAL OR OTHER INSTITUTION – Name (If not in either, give street and number)	7b. IF HOSP OR INST, Inpatient, Op./Emer. Room, DOA (Specify)	7c. CITY, VILLAGE, OR TOWNSHIP OF DEATH
Bay Medical Center	inpatient	Bay City

8. SOCIAL SECURITY NUMBER	9a. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	9b. KIND OF BUSINESS OR INDUSTRY
[redacted]	Bookeeper	Insurance Co.

10a. CURRENT RESIDENCE – STATE	10b. COUNTY	10c. LOCALITY (Check one box and specify)	10d. STREET AND NUMBER
MI	Bay	[X] INSIDE CITY OR VILLAGE OF Bay City [ ] TWP. OF	423 Nebobish

10e. ZIP CODE	11. BIRTHPLACE (City and State or Foreign Country)	12. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	13. SURVIVING SPOUSE (If wife, give name before first married)	14. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
48708	Bay City, MI	Widowed	none	NO

15. ANCESTRY – Mexican, Puerto Rican, Cuban, Central or South American, Chicano, other Hispanic, Afro-American, Arab, English, French, Finnish, etc. (Specify below)	16. RACE – American Indian, Black, White, etc. If Asian, give nationality i.e., Chinese, Filipino, Asian Indian, etc. (Specify below)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
Scottish	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Surname before first married)
John H. Reid	Anna Mae Metevia

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Village, State, ZIP Code)
Maxine Jones	515 Nebobish Bay City, MI 48708

DISPOSITION

21. METHOD OF DISPOSITION – Burial, Cremation, Removal, Donation, Other (specify)	22a. PLACE OF DISPOSITION (Name of Cemetery, Crematory, or other place)	22b. LOCATION – City or Village, State
Burial	Elm Lawn Cemetery	Bay City, MI

23. SIGNATURE OF FUNERAL SERVICE LICENSEE	24. LICENSE NUMBER (of Licensee)	25. NAME AND ADDRESS OF FACILITY
[signature]	6101	PENZIEN & STEELE FUNERAL HOME 608 N. Madison Ave. BAY CITY, MI 48708

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that 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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition → resulting in death)	a. Ruptured abdominal aortic aneurysm	6 hours
Sequentially list conditions, IF ANY, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

27a. WAS AN AUTOPSY PERFORMED? (Yes or No)	27b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
no	

CERTIFIER

28. ACTUAL PLACE OF DEATH (Home, Nursing Home, Hospital, Ambulance) (Specify)	29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Specify Yes or No)
hospital	no

CERTIFYING PHYSICIAN

30a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) David C. Reyes MD

30b. DATE SIGNED (Mo., Day, Yr.)	30c. TIME OF DEATH
10-29-91	5:43 A M

30d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

MEDICAL EXAMINER

31a. (Check One Only) [ ] The case reviewed and determined not to be a medical examiner's case. [ ] On the basis of examination and of investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated. (Signature and Title)

31b. DATE SIGNED (Mo., Day, Yr.)	31c. CASE NUMBER

31d. PRONOUNCED DEAD (Mo., Day, Yr.)	31e. TIME OF DEATH
ON	M

MEDICAL EXAMINER

32a. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type or Print)
David C. Reyes, M.D. 2110 16th St. Bay City, MI 48708

32b. LICENSE NUMBER
31875

MEDICAL EXAMINER

33a. ACC, SUICIDE, HOM, NATURAL OR PENDING INVEST (Specify)	33b. DATE OF INJURY (Mo., Day, Yr.)	33c. TIME OF INJURY	33d. DESCRIBE HOW INJURY OCCURRED
natural		M	

33e. INJURY AT WORK (Specify Yes or No)	33f. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify)	33g. LOCATION – Street or R.F.D. No. City, Village or Twp. State

34a. REGISTRAR'S SIGNATURE [signature] Barbara A. Albertson

34b. DATE FILED (Month, Day, Year) October 31, 1991

B-30
Rev. 1/90

FILED FOR RECORD
SKAMANIA CO. WASH
BY SKAMANIA CO. TITLE

OCT 13 2 33 PM '92

P. Lowry
AUDITOR
GARY M. OLSON

STATE OF MICHIGAN
County
City, Michigan

CERTIFIED COPY OF RECORD

I, BARBARA ALBERTSON, Clerk of the County of Bay, and of the Circuit Court [illegible] the same being a Court of Record having a Seal, do hereby certify that the following is a true copy of [illegible] remaining in my office, and of the whole thereof, viz:

In Testimony Whereof, I have hereunto set my hand and affixed the seal of said Circuit Court the [illegible] day of SEPTEMBER A.D. 19 92

BARBARA ALBERTSON, County Clerk

REAL ESTATE EXCISE TAX
OCT 13 1992
PAID Exempt
SKAMANIA COUNTY TREASURER

Registered 2-015308
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