STATE OF WASHINGTON
DEPARTMENT OF HEALTH

114891

BOOK 131 PAGE 892

[244]
LOCAL FILE NUMBER

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
VITAL RECORDS

CERTIFICATE OF DEATH

STATE FILE NUMBER 146

DECEDENT

1. NAME—FIRST, MIDDLE, LAST	2. SEX	3. DEATH DATE (Mo., Day, Yr.)
Nora Leona PROSCH	female	Mar. 3, 1989

4. AGE LAST BIRTHDAY (Yrs)	5. UNDER 1 YEAR MOS. DAYS	6. UNDER 1 DAY HOURS MINS	7. BIRTHDATE (Mo., Day, Yr.)	8. BIRTH STATE (If not in USA give country)	9. CITIZEN OF WHAT COUNTRY?	10. COUNTY OF DEATH
85			May 1, 1903	Oregon	USA	Clark

11. CITY, TOWN OR LOCATION OF DEATH	12. PLACE OF DEATH — ☒ BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG. ROOM/DOA 4 ☐ HOSP. 5 ☐ OWN HOME 6 ☐ OTHER PLACE	13. SMOKING IN LAST 15 YEARS? (Yes No)
Vancouver	St. Joseph's Community Hospital	no

14. MARITAL STATUS — Married, Never Married, Widowed, Divorced	15. SURVIVING SPOUSE (If wife, give maiden name)	16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No)	17. SOCIAL SECURITY NO.	18. HISPANIC ORIGIN?
married	Edwin L. Prosch	no	539 22 2830	no

19. USUAL OCCUPATION (Give kind of work during most of working life. DO NOT ACCEPT "RETIRED")	20. KIND OF BUSINESS OR INDUSTRY	21. Was Decedent of Hispanic Origin or descent? (Ancestry) (Specify Yes or No. If Yes specify: Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No	22. RACE (White, Black, Asian or Pacific Islander, Am. Ind., Eskimo, etc.) (Specify)
homemaker	own home		White

23. RESIDENCE - NUMBER AND STREET	24. CITY/TOWN, OR LOCATION	25. INSIDE CITY LIMITS? (Yes/No)	26. COUNTY	27. STATE	28. ZIP CODE
MP 10 76R St. Rd. 140	Washougal	no	Clark	Washington	98671

PARENTS

29. FATHER'S NAME—FIRST, MIDDLE, LAST	30. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
John Henry Lowe	Carrie Clark

31. INFORMANT—NAME	32. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)
Edwin L. Prosch	MP 10 76R St. Rd. 140 Washougal, WA 98671

DISPOSITION

33. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34. DATE (Mo., Day, Yr.)	35. CEMETERY/CREMATORY—NAME	36. LOCATION—CITY/TOWN, STATE
burial	Mar. 6, 1989	Evergreen Memorial Gardens	Vancouver, Wash.

37. FUNERAL DIRECTOR'S SIGNATURE	38. NAME OF FACILITY	39. ADDRESS OF FACILITY
X [signature]	Memorial Gardens Mort.	1101 NE 112th Ave. Vanc. WA 98684

CERTIFIER

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 O.F. Burris MD

42. DATE SIGNED (Mo., Day, Yr.): 3-7-89

43. HOUR OF DEATH (24 Hrs): 0030

40. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)
O.F. Burris, Dr. Hurst 3305 Main St. Vancouver, WA 98663

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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

44. DATE SIGNED (Mo., Day, Yr.)

45. HOUR OF DEATH (24 Hrs)

47. PRONOUNCED DEAD (Mo., Day, Yr.)

48. HOUR PRONOUNCED DEAD (24 Hrs)

CAUSE OF DEATH

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

		INTERVAL BETWEEN ONSET AND DEATH
(A)	MYOCARDIAL INFARCT	45 MIN
DUE TO, OR AS A CONSEQUENCE OF: (B)	Rt Colectomy	3 days
DUE TO, OR AS A CONSEQUENCE OF: (C)	CARCINOMA Rt COLON	6-12 MO.

51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE

52. AUTOPSY? (Yes, No): no

53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/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

61. REGISTRAR'S SIGNATURE
X [signature] REGISTRAR
SKAMANIA CO. WASH
BY SKAMANIA CO. TITLE

62. DATE RECEIVED (Mo., Day, Yr.): MAR 8 1989

DSHS 9-150 (Rev. 1-89) -1187-

Nov 6 12 41 PM '92
P. Towry
AUDITOR
GARY M. OLSON

Registered
Indexed, Dir
Indirect
Filmed 11/19/92
Mailed

DOH 01-003 (5/92)

CERTIFIED

NOV 3 1992

Karen Steingart
Dr. Karen Steingart
Health District Officer
S.W. Wash. Health Dist.

AA044575

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DECEDENT

1 NAME—FIRST, MIDDLE, LAST		2 SEX	3 DEATH DATE (Mo Day Yr)	
Nora Leona PROSCH		female	Mar. 3, 1989	146 STATE FILE NUMBER

4 AGE LAST BIRTHDAY (Yrs)	5 UNDER 1 YEAR MOS DAYS	6 UNDER 1 DAY HOURS MINS	7 BIRTHDATE (Mo Day Yr)	8 BIRTH STATE (If not in USA give country)	9 CITIZEN OF WHAT COUNTRY?	10 COUNTY OF DEATH
85			May 1,1903	Oregon	USA	Clark

11 CITY, TOWN OR LOCATION OF DEATH	12 PLACE OF DEATH — ☒ BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG TRMT OUT PTN 4 ☐ HOSP 5 ☐ NUR HOME 6 ☐ OTHER PLACE	13 SMOKING IN LAST 15 YEARS? (Yes No)
Vancouver	St. Joseph's Community Hospital	no

14 MARITAL STATUS — Married (Never Married, Widowed, Divorced)	15 SURVIVING SPOUSE (If wife, give maiden name)	16 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No)	17 SOCIAL SECURITY NO	18 HIGH SCHOOL GRADUATE? (Yes/No)
married	Edwin L. Prosch	no	539 22 2830	no

19 USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)	20 KIND OF BUSINESS OR INDUSTRY	21 Was Decedent of Hispanic Origin or Descent? (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XX 2 ☐ No	22 RACE (White, Black, American Indian, Asian or Pacific Islander, Eskimo, etc.) (Specify)
homemaker	own home		White

23 RESIDENCE NUMBER AND STREET	24 CITY, TOWN, OR LOCATION	25 INSIDE CITY LIMITS? (Yes/No)	26 COUNTY	27 STATE	28 ZIP CODE
MP 10 76R St. Rd. 140	Washougal	no	Clark	Washington	98671

PARENTS

29 FATHER'S NAME—FIRST, MIDDLE, LAST	30 MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
John Henry Lowe	Carrie Clark

31 INFORMANT—NAME	32 MAILING ADDRESS STREET OR RFD NO	CITY OR TOWN	STATE	ZIP
Edwin L. Prosch	MP 10 76R St. Rd. 140	Washougal,	WA	98671

DISPOSITION

33 BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34 DATE (Mo Day Yr)	35 CEMETERY/CREMATORY—NAME	36 LOCATION—CITY/TOWN, STATE
burial	Mar.6,1989	Evergreen Memorial Gardens	Vancouver, Wash.

37 FUNERAL DIRECTOR SIGNATURE	38 NAME OF FACILITY	39 ADDRESS OF FACILITY
X	Memorial Gardens Mort.	1101 NE 112th Ave. Vanc. WA 98684

CERTIFIER

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN	TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER
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 O.F. Burris 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) 3-7-89	43 HOUR OF DEATH (24 Hrs) 0030
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)
O.F. Burris / Dr. Hurst 3305 Main St. Vancouver, WA 98663

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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

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DUE TO, OR AS A CONSEQUENCE OF (B)	Rt colectomy	3 days
DUE TO, OR AS A CONSEQUENCE OF (C)	CARCINOMA Rt COLON	6-12 MO.

51 OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE	52 AUTOPSY? (Yes, No)	53 WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes, No)
	no	

54 ACC, SUICIDE, HO, 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

61 REGISTRAR SIGNATURE
X SKAMANIA CO. Karen Steingart MD

62 DATE RECEIVED (Mo Day Yr) MAR 8 1989

DSHS 9-150 (Rev. 1-89) •1187•

Registered
Indexed, Dir
Indirect
Filmed 11/17/92
Mailed

DOH 01-003 (5/92)

LEGAL RECORD
BY SKAMANIA CO. TITLE
Nov 6 12 41 PM '92
GARY M. OLSON

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH CENTER FOR HEALTH STATISTICS. CERTIFIED COPIES MUST HAVE THE OFFICIAL SEAL.

CERTIFIED
NOV 3 1992
Karen Steingart
Dr. Karen Steingart
Health District Officer
S.W. Wash. Health Dist.

AA044575