11517 BOOK 32 PAGE 599

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

1. NAME First	Middle	Last	2. SEX (M / F)	3. DEATH DATE (Mo, Day, Yr)
Robert	James	BROWN	Male	Sept. 20, 1992

4. AGE LAST BIRTHDAY (Yrs)	5. UNDER 1 YEAR MOS / DAYS	6. UNDER 1 DAY HOURS / MINS	7. BIRTHDATE (Mo, Day, Yr)	8. BIRTHPLACE (City, State or Foreign Country)	9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No)	10. COUNTY OF DEATH
69			Dec. 18,1922	Moccasin, Montana	Yes	Klickitat

11. CITY, TOWN OR LOCATION OF DEATH	12. PLACE OF DEATH—SEE BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1. ☐ HOME 2 ☐ IN TRANSPORT 3. ☐ EMERG. RM/OUT PT/N 4. ☒ HOSP. 5 ☐ OUR HOME 6 ☐ OTHER PLACE	13. SMOKING IN LAST 15 YEARS? (Yes / No)
White Salmon	Skyline Hospital	Yes

14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (If wife, give maiden name)	16. SOCIAL SECURITY NO.	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
Married	Frances Wombles	517-22-2377	12	

18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)	19. KIND OF BUSINESS OR INDUSTRY	20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify: No	21. RACE (Specify)
Postal Carrier	Postal Service		White

22. RESIDENCE—NUMBER AND STREET	23. CITY, TOWN, OR LOCATION	24. INSIDE CITY LIMITS? (Yes / No)	25A. COUNTY	25B. LENGTH OF RES. IN CO.	26. STATE	27. ZIP CODE
706 Fort Rains Drive	No. Bonneville	Yes	Skamania	2 Yrs.	Wa.	98639

28. FATHER'S NAME—FIRST, MIDDLE, LAST	29. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
George F. Brown	Maude S. Waldron

30. INFORMANT—NAME	31. MAILING ADDRESS STREET OR RFD NO.	CITY OR TOWN	STATE	ZIP
Frances Brown	P.O. Box 192	North Bonneville, Wa.		98639

32. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	33. DATE (Mo, Day, Yr)	34. CEMETERY/CREMATORY—NAME	35. LOCATION—CITY/TOWN, STATE
Rem/Crem.	9-22-1992	Win-Quatt Crematory	The Dalles, Oregon

36. FUNERAL DIRECTOR SIGNATURE	37. NAME OF FACILITY	38. ADDRESS OF FACILITY
X [signature]	Anderson Funeral Home	1401 Belmont,Hood River,Or.

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

39. TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED.

SIGNATURE AND TITLE
X [signature]

40. DATE SIGNED (Mo., Day, Yr)
9-22-92

41. HOUR OF DEATH (24 Hrs.)
2240

42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
Dr. David Dassoff, White Salmon, Wa.

43. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)
Dr. Robert Wymore, 1790 May St., Hood River, Oregon 97031

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

43. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED.

SIGNATURE AND TITLE
X

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

45. HOUR OF DEATH (24 Hrs)

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

47. HOUR PRONOUNCED DEAD (24 Hrs.)

48. ME/CORONER FILE NUMBER

49. FOR VITAL RECORDS

50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH: SKAMANIA CO WASH

IMMEDIATE CAUSE (Final disease or condition resulting in 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. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.	A: Myocardial Infarction	Dec 18 2 55 PM '92	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF: B.		INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF: C.	AUDITOR	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF: D.	GARY M. OLSON	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): No

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:
Natural Causes			

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
No		

61. REGISTRAR ACCEPTANCE (Signature) — REVIEWED BY — DATE

62. REGISTRAR SIGNATURE
X Karen Stannard, M.D.

63. DATE RECEIVED (Mo., Day, Yr.)
SEP 22 1992

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

DOH 110-003 (Rev. 7/91) (formerly DSHS 9-150)

Registered
Indexed, Dir
Indirect
Filmed
Mailed

Karen Stannard, M.D.

DOH 01-003 (7/89)

THIS IS A CERTIFIED COPY OF THE INFORMATION FILED WITH VITAL RECORDS. CERTIFIED COPIES HAVE THE OFFICIAL SEAL

District Health Officer

SEP 22 1992

Dr. Karen Stannard
Health District Officer

Unofficial Copy

E266747 H