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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER | STATE FILE NUMBER

COPIES: 3 | HOSPITAL | OCCURRENCE | RESIDENCE | FACT | OCCUPATION | INFORMANT | QUERIES

DECEDENT

1 NAME First	Middle	Last	2 SEX (M / F)	3 DEATH DATE (Mo, Day, Yr)
Ruth		Russell	Female	May 27, 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
81			6/11/10	Cavendish, Idaho	No	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. RM/OUT PTN 4 HOSP 5 NURSING HOME 6 OTHER PLACE)	13 SMOKING IN LAST 15 YEARS? (Yes / No)
Vancouver	5 Rose Vista Nursing Home	No

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	Everett Russell	537-20-1718	8 yrs.	

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	21 RACE (Specify)
Homemaker	Home	No	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
5001 Columbia View Dr.	Vancouver	Yes	Clark	1 yrs	WA	98661

28 FATHER'S NAME—FIRST, MIDDLE, LAST	29 MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
Homer Harper Michael	Myrtle Margaret Zinn

30 INFORMANT—NAME	31 MAILING ADDRESS STREET OR RFD NO	CITY OR TOWN	STATE	ZIP
Everett Russell	M.P. 34.11 SR 14	Skamania	WA	98648

32 BURIAL, CREMATION, REMOVAL, OTHER (Specify)	33 DATE (Mo, Day, Yr)	34 CEMETERY/CREMATORY—NAME	35 LOCATION—CITY/TOWN, STATE
Cremation	5/29/92	Park Hill Crematory	Vancouver, Washington

36 FUNERAL DIRECTOR SIGNATURE	37 NAME OF FACILITY	38 ADDRESS OF FACILITY
X Brian L Bartlett	Evergreen Staples Funeral Chapel	4700 St. Johns Rd Vancouver, Washington 98661

CERTIFIER

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 Timothy T. Ross MD

40 DATE SIGNED (Mo., Day, Yr)	41 HOUR OF DEATH (24 Hrs.)
May 28, 1992	1315

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

43 NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)
Dr. Timothy T. Ross, M.D. 1954 Ft. Vancouver Way Vancouver, WA 98663

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

CAUSE OF DEATH

50 ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:

FILED FOR RECORD
SKAMANIA CO. WASH.
BY Everett Russell
JAN 25 11 25
CARL D. WILSON

		INTERVAL BETWEEN ONSET AND DEATH
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. Acute respiratory failure	1 hr.
DUE TO, OR AS A CONSEQUENCE OF:	B. Acute bacterial pneumonia	2 wks.
DUE TO, OR AS A CONSEQUENCE OF:	C	
DUE TO, OR AS A CONSEQUENCE OF:	D	

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

Alzheimers dementia, dysphagia.

52 AUTOPSY? (Yes / 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 RECORD ATTACHMENT (Check if Less Only)

ITEM	DOCUMENTARY EVIDENCE	REVIEWED BY	DATE
Registered			
Indexed, Dir			
Indirect			
Filmed			
Mailed			

62 REGISTRAR SIGNATURE
X Karen Steingart, MD

63 DATE RECEIVED (Mo., Day, Yr.)
MAY 2 8 1992

DOH 110-008 (Rev. 7/91) (formerly DSHS 9-150)
A

DOH 01-003 (7/89)

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH VITAL RECORDS. CERTIFIED COPIES MUST HAVE THE OFFICIAL SEAL

HEALTH DISTRICT
FOR INSTRUCTIONS SEE BACK AND HANDBOOK
ASSISTANT

CERTIFIED

MAY 2 8 1992

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

150810 H