CERTIFICATION OF VITAL RECORD

168853C (1)

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

D-6720 I.D. TAG NO. 116771

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

BOOK 136 PAGE 832

Local File Number: 00083

136-

93-000588 State File Number

1. DECEDENT'S NAME: First: Donald; Middle: Lee; Last: MAY			2. SEX: Male	3. DATE OF DEATH (Month, Day, Year): January 3, 1993
4. SOCIAL SECURITY NUMBER: 535-34-3695	5a. AGE-Last Birthday (Years): 57	5b. Under 1 Year: Mos. / Days	5c. Under 1 Day: Hours / Mins.	6. BIRTHPLACE (City and State or Foreign Country): Great Falls, MT
7. DATE OF BIRTH (Month, Day, Year): December 22, 1935				
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No				
9a. PLACE OF DEATH (Check only one): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)				
9b. FACILITY NAME (If not institution, give street and number): Bess Kaiser Medical Center	9c. CITY, TOWN, OR LOCATION OF DEATH: Portland	9d. COUNTY OF DEATH: Multnomah		
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Pharmacist	10b. KIND OF BUSINESS/INDUSTRY: Pharmaceutical Sales	11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married	12. SPOUSE (If Married, Widowed): Marie May	
13a. RESIDENCE - STATE: Washington	13b. COUNTY: Clark	13c. CITY, TOWN OR LOCATION: Battle Ground	13d. STREET AND NUMBER: 10438 NE 219th Street	
13e. INSIDE CITY LIMITS? ☐ Yes ☒ No	13f. ZIP CODE: 98604	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes	15. RACE American Indian, Black, White, etc. (Specify): White	16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5½; College (1-4 or 5+):
17. FATHER - NAME first middle last: Cyril Sargent May	18. MOTHER - NAME first middle maiden: Charlotte Young	19. INFORMANT - NAME and relationship to deceased: Marie May - Wife		
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	20c. LOCATION - City or Town, State: Vancouver, Washington		
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Dexter F. Hanks	21b. LICENSE NUMBER (Of Licensee): 1397	22. NAME, ADDRESS AND ZIP CODE OF FACILITY: Layne & Funeral, 16 N. Clark Av, P.O. Box 7, Battle Ground, Washington 98604		
23. DATE FILED (Month, Day, Year): JAN 14 1993	24. REGISTRAR'S SIGNATURE: Edward J. Olson			
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☒ YES ☐ NO ☐ N/A	26. WAS GIFT MADE? ☐ YES ☒ NO ☐ N/A			

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 10:40 PM	28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes XX 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): Steward Levy

30. DATE SIGNED (Month, Day, Year): 1-6-93

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH: M	31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour): M

32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature):

33. DATE SIGNED (Month, Day, Year) COUNTY

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Steward Levy, MD, 2211 E. Mill Pain Blvd., Vancouver, Washington 98661

35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print): TOM SYLTEBO, M.D.

36. 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.

PART I (a)	Congestive Heart Failure	Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF: (b)	Cor Pulmonale	Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF: (c)	COPD	Interval between onset and death
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART 1.		

37. Did tobacco use contribute to the death? ☐ Yes ☐ No ☐ Probably ☐ Unk	38. AUTOPSY ☐ Yes ☒ No	39. If YES were findings considered in determining cause of death? ☐ Yes ☐ No ☐ N/A

40. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY M	41c. INJURY AT WORK? ☐ Yes ☐ No
41d. DESCRIBE HOW INJURY OCCURRED			
41e. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)	41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

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13963
REAL ESTATE EXCISE TAX
JUL 19 1993
PAID Exempt

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON STATE HEALTH DIVISION.

SKAMANIA COUNTY

MAR 16 1993
DATE ISSUED

Edward J. Johnson II
EDWARD J. JOHNSON II,
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

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

JUL 19 3 30 PM '93
P. Lowry
AUDITOR
GARY M. OLSON