STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF HEALTH

LOCAL FILE NUMBER **116994** **CERTIFICATE OF DEATH** BOOK 137 PAGE 340

DECEDENT

1 NAME—FIRST MIDDLE LAST	2 SEX	3 DEATH DATE (Mo. Day. Yr.)	STATE FILE NUMBER
William W. NELSON	Male	08 Apr 1989	146

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
78			3/16/1911	Washington	U.S.A.	Clark

11 CITY, TOWN OR LOCATION OF DEATH	12 PLACE OF DEATH — ☐ HOME ☐ IN TRANSPORT ☐ EMERG. RM/OUT PTH ☐ HOSP ☒ NURS HOME ☐ OTHER PLACE	13 SMOKING IN LAST 15 YEARS? (Yes/No)
Vancouver	Highland Terrace Nursing Home	Yes

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	Phylis M. Krause	NO	542-03-2801	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? (Ancestry) (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No	22 RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc.) (Specify)
Powerhouse Operator	Corps of Engineers		White

23 RESIDENCE - NUMBER AND STREET	24 CITY/TOWN OR LOCATION	25 INSIDE CITY LIMITS? (Yes/No)	26 COUNTY	27 STATE	28 ZIP CODE
P.O. Box 414	Stevenson	Yes	Skamania	Washington	98648

PARENTS

29 FATHER'S NAME—FIRST, MIDDLE, LAST	30 MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
Frank B. Nelson	Mabel - Butts

DISPOSITION

31 INFORMANT—NAME	32 MAILING ADDRESS (STREET OR RFD NO., CITY OR TOWN, STATE, ZIP)
Phylis Nelson	P.O. Box 414 Stevenson, WA 98648

33 BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34 DATE (Mo. Day. Yr.)	35 CEMETERY/CREMATORY—NAME	36 LOCATION—CITY/TOWN, STATE
Burial	4/12/89	Stevenson Cemetery	Stevenson, WA

37 FUNERAL DIRECTOR SIGNATURE	38 NAME OF FACILITY	39 ADDRESS OF FACILITY
X [signature]	GARDNER FUNERAL HOME, INC.	Box 390 White Salmon, WA 98672

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 [signature] Lorence

42 DATE SIGNED (Mo. Day. Yr.) 4/14/89
43 HOUR OF DEATH (24 Hrs.) 1305

46 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)
Dr. Lorence 19500 SE Stark Portland, OR 97233

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

(a) Chronic Obstructive Pulmonary Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO OR AS A CONSEQUENCE OF
(b) Hypertension — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO OR AS A CONSEQUENCE OF
(c) — 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, HOMICIDE, 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 Karen Steingart, M.D.
62 DATE RECEIVED (Mo. Day. Yr.) APR 24 1989

DSHS 9-150 (Rev. 1-85) *187*

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APR 24 1989

SEAL

Karen Steingart, M.D.
KAREN STEINGART, M.D.
DISTRICT HEALTH OFFICER

016013
REAL ESTATE EXCISE TAX
AUG 12 1993
PAID exempt

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

After Recording Return to:

James Nelson
P.O. Box 276
Hood River, OR 97031

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P. Lowry
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