116869 | 04890 ID TAG NO. | 121-86 Local File Number

STATE OF OREGON
OREGON STATE HEALTH DIVISION
DEPARTMENT OF HUMAN SERVICES
Vital Records Unit

BOOK 137 PAGE 55

CERTIFICATE OF DEATH

State File Number

TYPE OR PRINT IN PERMANENT BLACK INK. FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT

1 DECEASED — NAME First	Middle	Last	2 DATE OF DEATH (month, day, year)
Gordon	Clarence	BAKER	October 27, 1986

3 RACE White, Black, American Indian, etc (Specify)	4 SEX	5a AGE — Last birthday (years)	Under 1 year: 5b mos. / days	Under 1 day: 5c hours / min.	6 DATE OF BIRTH (month, day, year)
White	Male	86			September 27, 1900

7a CITY, TOWN OR LOCATION OF DEATH	7b HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number)	7c IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (specify)	7d COUNTY OF DEATH
Hood River	Hood River Care Center	Inpatient	Hood River

8 STATE OF BIRTH (If not in U.S.A., name country)	9 CITIZEN OF WHAT COUNTRY	10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	11 SPOUSE (IF MARRIED, WIDOWED)	12 WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no)
Illinois	U.S.A.	Married	Sarah E.	No

13 SOCIAL SECURITY NUMBER	14a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14b KIND OF BUSINESS OR INDUSTRY
534-14-8241	Farmer	Agriculture

15a RESIDENCE — STATE	15b COUNTY	15c CITY, TOWN OR LOCATION	15d STREET AND NUMBER OR R.F.D. ZIP	15e Inside City Limits (specify yes or no)
Washington	Skamania	Underwood	Star Route Box 128 ZIP 98651	No

16 FATHER — NAME first middle last	17 MOTHER — first middle last (Maiden Name)	18 INFORMANT — NAME and relationship to deceased
Charles - Baker	Cora - Rice	Betty Baker, Wife

19a BURIAL, CREMATION, REMOVAL, MAUS. (specify)	19b CEMETERY OR CREMATORY — NAME	19c LOCATION city or town state
Rem/Burial	Klickitat County Dist. #1	White Salmon, WA

DISPOSITION

20a FUNERAL SERVICE LICENSEE or person acting as such (Signature)	20b NAME AND ADDRESS OF FACILITY
Keren L. Duerksen	GARDNER FUNERAL HOME, INC. White Salmon, WA

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only

To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated

21a (Signature)	21b DATE SIGNED (Mo., Day, Year)	21c HOUR OF DEATH
[signature] MD	10-29-86	2050 M

21d NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print) ZIP:
John Kaiser, M.D. Family Health Center White Salmon, WA 98672

21e NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

22a DATE RECEIVED BY REGISTRAR (Mo., Day, Year)	22b REGISTRAR (Signature)
OCT 30 1986	[signature]

CAUSE OF DEATH

PART I

	23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)	Interval between onset and death
(a)	cardiopulmonary arrest	4min
DUE TO, OR AS A CONSEQUENCE OF: (b)	renal failure	2wks.
DUE TO, OR AS A CONSEQUENCE OF: (c)		

PART II — OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I (a)

24 AUTOPSY (Specify Yes or No)	25 WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No)
No	No

26a ACCIDENT (Specify Yes or No)	26b DATE OF INJURY (Mo., Day, Year)	26c HOUR OF INJURY	26d DESCRIBE HOW INJURY OCCURRED
No		M	

26e INJURY AT WORK (Specify Yes or No)	26f PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26g LOCATION STREET OR R.F.D. NO.	CITY OR TOWN	STATE
No				

DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES ☐ NO ☐ N/A ☒

WAS GIFT MADE? YES ☐ NO ☐ N/A

RESERVED FOR REGISTRAR'S USE

FILED FOR RECORD
SKAMANIA CO. WASH
BY David C. Baker

ORIGINAL—VITAL STATISTICS COPY

45-2 Rev. 1-86

AUG 2 11 51 AM '93
P. Lowry
AUDITOR
GARY M. OLSON

STATE OF OREGON
COUNTY OF HOOD RIVER

This certifies that the foregoing is a correct and complete transcript of a record of death on file with the HOOD RIVER COUNTY PUBLIC HEALTH DEPARTMENT.

[signature]
County Registrar of Vital Statistics

October 30, 1986
Date

NOT VALID WITHOUT RAISED SEAL OF HOOD RIVER COUNTY HEALTH DEPARTMENT

Registered
Indexed, Dir
Indirect
Filmed
Mailed

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CERTIFICATE OF DEATH

State File Number

Field	Entry
1 Decedent — Name (First, Middle, Last)	Gordon Clarence BAKER
2 Date of Death	October 27, 1986
3 Race	White
4 Sex	Male
5a Age — Last birthday (years)	86
6 Date of Birth	September 27, 1900
7a City, Town or Location of Death	Hood River
7b Hospital or Other Institution — Name	Hood River Care Center
7c If Hosp. or Inst. Indicate DOA, OP/Emer. Rm., Inpatient	Inpatient
7d County of Death	Hood River
8 State of Birth	Illinois
9 Citizen of What Country	U.S.A.
10 Married, Never Married, Widowed, Divorced	Married
11 Spouse	Sarah E.
12 Was Decedent Ever in U.S. Armed Forces?	No
13 Social Security Number	534-14-8241
14a Usual Occupation	Farmer
14b Kind of Business or Industry	Agriculture
15a Residence — State	Washington
15b County	Skamania
15c City, Town or Location	Underwood
15d Street and Number or R.F.D.	Star Route Box 128
Zip	98651
15e Inside City Limits	No
16 Father — Name	Charles - Baker
17 Mother — Name (Maiden Name)	Cora - Rice
18 Informant — Name and relationship to deceased	Betty Baker, Wife
19a Burial, Cremation, Removal, Other	Rem/Burial
19b Cemetery or Crematory — Name	Klickitat County Dist. #1
19c Location	White Salmon, WA
20a Funeral Service Licensee (Signature)	[signature]
20b Name and Address of Facility	GARDNER FUNERAL HOME, INC. White Salmon, WA
21a Certifier (Signature)	[signature]
21b Date Signed	10-29-86
21c Hour of Death	2050 M
21d Name, Title and Address of Certifier	John Kaiser, M.D. Family Health Center White Salmon, WA 98672
21e Name of Attending Physician if Other Than Certifier	
22a Date Received by Registrar	OCT 30 1986
22b Registrar (Signature)	[signature]
23 Part I (a) Immediate Cause	cardiopulmonary arrest — Interval: 4 min
(b) Due to, or as a consequence of	renal failure — Interval: 2 wks.
(c) Due to, or as a consequence of	
Part II Other Significant Conditions	
24 Autopsy	No
25 Was Medical Examiner Notified	No
26a Accident	No
26b Date of Injury	
26c Hour of Injury	
26d Describe How Injury Occurred	
26e Injury at Work	No
26f Place of Injury	
26g Location	
Did hospital representative make request for anatomical gift consent?	Yes ☐ No ☐ N/A ☒
Was gift made?	Yes ☐ No ☐
Reserved for Registrar's Use	

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SKAMANIA CO. WASH
BY David C. Baker

Aug 2 11 51 AM '93
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