STATE OF WASHINGTON
DEPARTMENT OF HEALTH

TYPE OR PRINT IN PERMANENT BLACK INK

32 123613 LOCAL FILE NUMBER

Health

CERTIFICATE OF DEATH

BOOK 153 PAGE 175
146
STATE FILE NUMBER

1. NAME First Middle Last: Kenneth Walter KUSKIE
2. SEX (M/F): Male
3. DEATH DATE (Mo, Day, Yr): Oct 8 1995
4. AGE-LAST BIRTHDAY (Years): 74
5. UNDER 1 YEAR Mos. Days
6. UNDER 1 DAY Hours Min.
7. BIRTHDATE (Mo, Day, Yr): May 9 1921
8. BIRTHPLACE (City and State or Foreign Country): Cody WY
9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No): Yes
10. COUNTY OF DEATH: Skamania
11. CITY, TOWN OR LOCATION OF DEATH: Stevenson
12. PLACE OF DEATH: 651 W Vancouver
13. INSIDE CITY LIMITS? (Yes/No): Yes
14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
15. SURVIVING SPOUSE (If wife, give maiden name): Tess Mary Oeppen
16. SOCIAL SECURITY NO.: 534 12 9047
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+)
19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED): Groundsman
20. KIND OF BUSINESS OR INDUSTRY: Public Utilities
21. Was Decedent of Hispanic Origin? (Yes/No) Specify: No
22. RACE (Specify): White
23. RESIDENCE—NUMBER AND STREET: 651 W Vancouver
24. CITY/TOWN, OR LOCATION: Stevenson
25. INSIDE CITY LIMITS: Yes
26. COUNTY: Skamania
27. LENGTH OF RES. IN CO.: 70 yrs
28. STATE: Washington
29. ZIP CODE: 98648
30. FATHER'S NAME—FIRST, MIDDLE, LAST: Francis LeRoy Kuskie
31. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME: Florence C Smith
32. INFORMANT—NAME: Tess M Kuskie
33. MAILING ADDRESS: POB 202 Stevenson WA 98648
34. BURIAL, CREMATION, REMOVAL, OTHER (Specify): Cremation
35. DATE (Mo, Day, Yr): 10/10/95
36. CEMETERY/CREMATORY—NAME: Win-quatt Crematory
37. LOCATION—CITY/TOWN, STATE: The Dalles OR
38. FUNERAL DIRECTOR OR SIGNATURE: C. M. [signature]
39. NAME OF FACILITY: GARDNER FUNERAL HOME INC.
40. ADDRESS OF FACILITY: POB 390 WHITE SALMON WA 98672

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN
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]
DATE SIGNED (Mo, Day, Yr): 10/10/95
HOUR OF DEATH (24 Hrs): 0800
NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER
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
DATE SIGNED (Mo, Day, Yr)
HOUR OF DEATH (24 Hrs)
PRONOUNCED DEAD (Mo, Day, Yr)
HOUR PRONOUNCED DEAD (24 Hrs)

NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER, CORONER (Type or Print): Gregory Zuck, M.D. POB 1519 White Salmon, WA 98672
ME/CORONER FILE NUMBER

ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH.
IMMEDIATE CAUSE
a. Transitional Cell Carcinoma – Kidney — Interval between onset and death: 1 3 yrs
b. DUE TO, OR AS A CONSEQUENCE OF
c. DUE TO, OR AS A CONSEQUENCE OF
d. DUE TO, OR AS A CONSEQUENCE OF

FILED FOR RECORD
SKAMANIA CO. WASH
BY Robert Leick
OCT 23 4 10 PM '95
G. Olson
AUDITOR
GARY M. OLSON

OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE
AUTOPSY (Yes/No): No
WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No): Yes
ACC. SUICIDE, HOMI., UNDET., OR PENDING INVEST. (Specify)
INJURY DATE (Mo, Day, Yr)
HOUR OF INJURY (24 Hrs)
INJURY AT WORK? (Yes/No)
PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE BLDG, ETC. (Specify)
LOCATION (STREET AND NO., CITY/TOWN, STATE)

Registered ✓
Indexed, Dir ✓
Indirect ✓
Filmed
Mailed

RECORD AMENDMENT ITEM / AMENDED BY / DATE
REGISTRAR SIGNATURE: X [signature]
DATE RECEIVED (Mo, Day, Yr): 10-11-95

SEE INSTRUCTIONS ON BACK AND HANDBOOK

CERTIFIED

OCT 11 1995

[signature]
Dr. Karen Steingart
Health District Officer
S.W. Wash

00438992

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

TYPE OR PRINT IN PERMANENT BLACK INK

32 123613
LOCAL FILE NUMBER

Washington State Department of Health

CERTIFICATE OF DEATH

BOOK 153 146 PAGE 176

STATE FILE NUMBER

Field	Entry
1. Name (First, Middle, Last)	Kenneth Walter KUSKIE
2. Sex (M / F)	Male
3. Death Date (Mo, Day, Yr)	Oct 8 1995
4. Age Last Birthday (Yrs)	74
5. Under 1 Year (Mos / Days)	
6. Under 1 Day (Hours / Mins)	
7. Birthdate (Mo, Day, Yr)	May 9 1921
8. Birthplace (City, State or Foreign Country)	Cusk WY
9. Was Decedent Ever in U.S. Armed Forces? (Yes / No)	
10. County of Death	Skamania
11. City, Town or Location of Death	Stevenson
12. Place of Death (1 Home, 2 ER/Outpatient, 3 DOA, 4 Hosp, 5 Nursing Home, 6 Other)	Home — 651 W Vancouver
13. Washington Last 15 Years? (Yes / No)	Yes
14. Marital Status — Married, Never Married, Widowed, Divorced (Specify)	Married
15. Surviving Spouse (If wife, give maiden name)	Tess Mary Oeppen
16. Social Security No.	534 12 9047
17. Decedent's Education (Elementary/Secondary 0-12; College 1-4 or 5+)	12
18. Usual Occupation (Give kind of work done during most of working life. DO NOT USE RETIRED)	Groundsman
19. Kind of Business or Industry	Public Utilities
20. Was Decedent of Hispanic origin or descent? (Yes / No) Specify	No
21. Race (Specify)	White
22. Residence — Number and Street	651 W Vancouver
23. City/Town, or Location	Stevenson
24. Inside City Limits? (Yes / No)	Yes
25a. County	Skamania
25b. Length of Res. in Co.	70 yrs
26. State	Washington
27. Zip Code	98648
28. Father's Name — First, Middle, Last	Francis LeRoy Kuskie
29. Mother's Name — First, Middle, Maiden Surname	Florence C Smith
30. Informant — Name	Tess M Kuskie
31. Mailing Address (Street or RFD No., City or Town, State, Zip)	POB 202 Stevenson WA 98648
32. Burial, Cremation, Removal, Other (Specify)	Cremation
33. Date (Mo, Day, Yr)	10/10/95
34. Cemetery/Crematory — Name	Win-quatt Crematory
35. Location — City/Town, State	The Dalles OR
36. Funeral Director Signature	x C. M. [signature]
37. Name of Facility	GARDNER FUNERAL HOME INC.
38. Address of Facility	POB 390 WHITE SALMON WA 98672

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

Field	Entry
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)	10/10/95
41. Hour of Death (24 Hrs)	0800
42. Name and Title of Attending Physician if Other Than Certifier (Type or Print)	

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

Field	Entry
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)	

Field	Entry
48. Name and Address of Certifier — Physician, Medical Examiner or Coroner (Type or Print)	Gregory Zuck, M.D. POB 1519 White Salmon, WA 98672
49. ME/Coroner File Number	

50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE 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.

Line	Cause	Interval Between Onset and Death
A	Transitional Cell Carcinoma - Kidney	1 3yrs
B	Due to, or as a consequence of	
C	Due to, or as a consequence of	
D	Due to, or as a consequence of	

FILED FOR RECORD
SKAMANIA CO. WASH
BY Robert Luck
OCT 23 4 20 PM '95
G. Olson
AUDITOR
GARY H. OLSON

Field	Entry
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)	Yes
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 Amendment (Registrar use only) — Item / Incorrect/Typo / Reviewed By / Date	
62. Registrar	x [signature]
63. Date Received (Mo, Day, Yr)	10-11-95

Registered
Indexed, Dir
Indirect
Filmed
Mailed

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

DOH 110-019 (Rev. 7/91)

CERTIFIED

OCT 11 1995

[signature]
Dr. Karen Steingart
Health District Officer
S.W. Wash.

0043899