CERTIFICATION OF VITAL RECORD

59386 — OREGON DEPARTMENT OF HUMAN RESOURCES

I.D. TAG NO. 122959 — HEALTH DIVISION, Vital Records Unit — BOOK 154 PAGE 49

090 — CERTIFICATE OF DEATH — 136

Local File Number — State File Number

1. DECEDENT'S NAME: First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)
Robert	H.	TICHENOR	M	May 7, 1992

4. SOCIAL SECURITY NO.	5a. AGE - Last Birthday (Years)	5b. Under 1 Year: Months	Days	5c. Under 1 Day: Hours	Min.	6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Month, Day, Year)
540-32-0069	79					Salem, OR	June 29, 1912

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No

8a. PLACE OF DEATH (Check only one): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)

8b. FACILITY NAME (If not institution, give street and number)	8c. CITY, TOWN, OR LOCATION OF DEATH	8d. COUNTY OF DEATH
Mid-Columbia Medical Center	The Dalles	Wasco

9a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	9b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	12. SPOUSE (If Married, Widowed)
Meat cutter/owner	Grocery	Married	Lorena S.

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Washington	Skamania	Stevenson	199 NW Del Ray

13e. INSIDE CITY LIMITS?	13f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	15. RACE - American Indian, Black, White, etc. (Specify)	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
☐ Yes ☐ No	98648	☐ No ☐ Yes	White	12	

17. FATHER - NAME first middle last	18. MOTHER - NAME first middle maiden	19. INFORMANT - NAME and relationship to decedent
Grover - Tichenor	Anna - Devlin	Lorena Tichenor, Wife

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - City or Town, State
☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)	Stevenson Cemetery	Stevenson, WA

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (Of Licensee)	22. NAME, ADDRESS AND ZIP OF FACILITY
R. L. Dierdorff	1482	GARDNER FUNERAL HOME, INC. Box 390 White Salmon, WA 98672

23. DATE FILED (Month, Day, Year)	24. REGISTRAR'S SIGNATURE
May 20, 1992	Sheila Richmond, Deputy

25a. HOSPITAL REPRESENTATIVE ASKED REQUEST FOR ANATOMICAL GIFT CONSENT?	25b. WAS GIFT MADE?
☐ Yes ☐ NO ☐ NA	☐ Yes ☐ NO ☐ NA

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH	28. WAS MEDICAL EXAMINER NOTIFIED?
2005	☐ Yes ☒ 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) Thomas H. Hodge MD

30. DATE SIGNED (Month, Day, Year) May 12 1992

31. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print): Thomas Hodge, M.D. 1825 E. 19th Suite 1 The Dalles, OR 97058

32. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

33a. TIME OF DEATH	33b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour)

34. 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)

35. DATE SIGNED (Month, Day, Year) — COUNTY

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

PART I		Interval between onset and death
36. a. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE) (a), (b), AND (c). Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.	Ventricular Fibrillation	
b. DUE TO, OR AS A CONSEQUENCE OF:	Coronary Heart Disease	
c. DUE TO, OR AS A CONSEQUENCE OF:		
PART II 37. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I.		

37. Did tobacco use contribute to the death?	38. AUTOPSY	39. Were findings considered in determining cause of death?
☐ Yes ☐ No ☐ Probably ☐ Unk	☐ Yes ☒ No	☐ Yes ☐ No ☐ NA

40. MANNER OF DEATH	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY	41c. INJURY AT WORK?	41d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention			☐ Yes ☐ No	

41e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	41f. LOCATION (Street and Number or R.F.D. Number, City or Town, State)

FILED FOR RECORD SKAMANIA CO. WASH

BY SKAMANIA CO. TITLE

RESERVED FOR REGISTRAR'S USE

Dec 5 4 11 PM '95

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AUDITOR
GARY M. OLSON
Carla Chamberlain

CARLA CHAMBERLAIN
COUNTY REGISTRAR
WASCO COUNTY, OREGON

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CERTIFICATION OF VITAL RECORD

99386 I.D. TAC NO. 123959 990 Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

BOOK 154 PAGE 49 136

State File Number

DECEDENT

1. DECEDENT'S NAME	First	Middle	Last	2. SEX	3. DATE OF DEATH (Month, Day, Year)
	Robert	H.	TICHENOR	M	May 7, 1992

4. SOCIAL SECURITY NUMBER	5a. AGE-Last Birthday (Years)	5b. Under 1 Year Mos.	Days	5c. Under 1 Day Hours	Min.	6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Month, Day, Year)
540-32-0069	79					Salem, OR	June 29, 1912

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ No ☐ Yes

8a. PLACE OF DEATH (CHECK only one)
HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)

8b. FACILITY NAME (If not institution, give street and number)	8c. CITY, TOWN, OR LOCATION OF DEATH	8d. COUNTY OF DEATH
Mid-Columbia Medical Center	The Dalles	Wasco

9a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	9b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS - (Married, Never Married, Widowed, Divorced) (Specify)	12. SPOUSE (If Married, Widowed)
Meat cutter/owner	Grocery	Married	Lorena S.

12a. RESIDENCE - STATE	12b. COUNTY	12c. CITY, TOWN, OR LOCATION	12d. STREET AND NUMBER
Washington	Skamania	Stevenson	199 NW Del Ray

12e. INSIDE CITY LIMITS? ☐ Yes ☐ No	12f. ZIP CODE	14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify:	15. RACE American Indian, Black, White, etc. (Specify)	16. DEGREE - LEVEL OF EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
	98648		White	12	

17. FATHER - NAME first middle last	18. MOTHER - NAME first middle maiden	19. INFORMANT NAME and relationship to deceased
Grover - Tichenor	Anna - Devlin	Lorena Tichenor, Wife

20a. METHOD OF DISPOSITION ☐ Mausoleum ☒ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c. LOCATION - City or Town, State
	Stevenson Cemetery	Stevenson, WA

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (If Licensed)	22. NAME, ADDRESS AND ZIP OF FACILITY
K. F. Dierick	1482	GARDNER FUNERAL HOME, INC. Box 390 White Salmon, WA 98672

23. DATE FILED (Month, Day, Year)	24. REGISTRAR'S SIGNATURE
May 20, 1992	Linda Osmond Deputy

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	28. WAS MEDICAL EXAMINER NOTIFIED?
2005	☐ Yes ☒ No

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M	M

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35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CAUSE OF DEATH

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

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) as a consequence of Vertebrobasilar Insufficiency — Interval between onset and death
(b) due to, or as a consequence of Coronary Heart Disease — Interval between onset and death
(c) — Interval between onset and death

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

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

40. MANNER OF DEATH	41a. DATE OF INJURY (Month, Day, Year)	41b. TIME OF INJURY	41c. INJURY AT WORK?	41d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined ☐ Legal Intervention		M	☐ Yes ☐ No	FILED FOR RECORD SKAMANIA CO. WASH BY SKAMANIA CO. TITLE

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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