

135375

BOOK 190 PAGE 132

FILED FOR RECORD
SKAGWAY CO. WASH
BY SEANADIA CO. TITLE

JUN 9 2 45 PM '99

Garry
AUDITOR
GARY M. OLSON

AFTER RECORDING MAIL TO:

Name Diana K. Christopher

Address 6951 Shane Place

City/State Anchorage, AK 99507

Sec 22695

Document Title(s): (or transactions contained therein)

1. Death Certificate
- 2.
- 3.
- 4.

Reference Number(s) of Documents assigned or released:

☐ Additional numbers on page _____ of document

Grantor(s): (Last name first, then first name and initials)

1. Christopher, Richard W
- 2.
- 3.
- 4.

5. ☐ Additional names on page _____ of document

Grantee(s): (Last name first, then first name and initials)

1. Christopher, Diana K.
- 2.
- 3.
- 4.

5. ☐ Additional names on page _____ of document

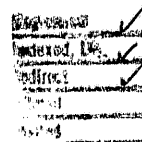
Abbreviated Legal Description as follows: (i.e. lot/block/plot or section/township/range/quarter/quarter)

☐ Complete legal description is on page _____ of document

Assessor's Property Tax Parcel / Account Number(s):

WA-1

NOTE: The auditor/recorder will rely on the information on the form. The staff will not read the document to verify the accuracy or completeness of the indexing information provided herein.



CERTIFICATION OF VITAL RECORD

197198
I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
136

BOOK 190 PAGE 133

Local File Number

State File Number

1. DECEDENT'S NAME First: <u>Richard</u> Middle: <u>W</u> Last: <u>CHRISTOPHER</u>		2. SEX <u>Male</u>	3. DATE OF DEATH (Month, Day, Year) <u>February 7, 1996</u>																																																																																
4. SOCIAL SECURITY NUMBER <u>542-18-0460</u>		5a. AGE-Last Birthday (Years) <u>80</u>	5b. Under 1 Year MCS: <u> </u> Days: <u> </u>																																																																																
6. PLACE OF DEATH (Check only one) ☐ Hospital ☐ Inpatient ☐ Outpatient ☐ DCA ☒ OTHER ☒ Nursing Home ☐ Decedent's Home ☐ Other (Specify): <u> </u>		7. DATE OF BIRTH (Month, Day, Year) <u>November 26, 1915</u>																																																																																	
8. FACILITY NAME (If not institution, give street and number) <u>Bishop Morris Care Center</u>		9. CITY, TOWN, OR LOCATION OF DEATH <u>Portland</u>																																																																																	
10. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Electrician</u>		11. MARRITAL STATUS - <u>Married</u> (If Married, Widowed, Divorced (Specify)) <u>Widowed</u>																																																																																	
12. RESIDENCE - STATE <u>Washington</u>		13. COUNTY <u>Skamania</u>																																																																																	
14. INSIDE CITY LIMITS ☐ Yes ☒ No		15. RACE American Indian, Black, White, etc. (Specify) <u>White</u>																																																																																	
16. FATHER - NAME first middle last <u>Walter - Christopher</u>		17. MOTHER - NAME first middle maiden <u>Lyda -</u>																																																																																	
18. METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify): <u> </u>		19. INFORMATION - NAME and relationship to decedent <u>Diana Christopher - Daughter</u>																																																																																	
20. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <u>Paul Butterfield</u>		21. LICENSE NUMBER (If Licensed) <u>3073</u>																																																																																	
22. DATE FILED (Month, Day, Year) <u>FEB 12 1996</u>		23. REGISTRAR'S SIGNATURE <u>[Signature]</u>																																																																																	
24. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☐ YES ☒ NO ☐ N/A		25. WAS GIFT MADE? ☐ YES ☒ NO ☐ N/A																																																																																	
<table border="1"> <tr> <td colspan="2">TO BE COMPLETED BY CERTIFYING PHYSICIAN</td> <td colspan="2">TO BE COMPLETED ONLY BY MEDICAL EXAMINER</td> </tr> <tr> <td>27. TIME OF DEATH <u>10:00</u> A M ☐ P M</td> <td>28. WAS MEDICAL EXAMINER NOTIFIED? ☒ Yes ☐ No</td> <td>31a. TIME OF DEATH <u> </u> H <u> </u> M</td> <td>31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) <u> </u> M <u> </u> D <u> </u> Y <u> </u> H</td> </tr> <tr> <td colspan="2">29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. <u>[Signature]</u></td> <td colspan="2">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. <u>[Signature]</u></td> </tr> <tr> <td colspan="2">30. DATE SIGNED (Month, Day, Year) <u>2-8-96</u></td> <td colspan="2">33. DATE SIGNED (Month, Day, Year) <u> </u> COUNTY <u> </u></td> </tr> <tr> <td colspan="4">34. 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ORIGINAL-VITAL STATISTICS COPY

45-2 Rev 12/84

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE MULTNOMAH COUNTY REGISTRAR.

FEB 12 1996

DATE ISSUED:

GARY L. OXMAN, M.D.
COUNTY REGISTRAR
MULTNOMAH COUNTY, OREGON

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE