CERTIFICATION OF VITAL RECORD

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

115067

BOOK 132 PAGE 297

31883 ID TAG NO

2024 Local File Number

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

87-015866 State File Number

CERTIFICATE OF DEATH

02 TYPE OR PRINT IN PERMANENT BLACK INK

FOR INSTRUCTIONS SEE HANDBOOK 01

DECEDENT

IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

1. DECEASED — NAME: First: Maurice; Middle: Edward; Last: O'NEIL
2. DATE OF DEATH (month day year): August 30, 1987
3. RACE (White, Black, American Indian, etc. (specify)): White
4. SEX: Male
5a. AGE — Last birthday (years): 66
5b. Under 1 year: Months / Days
5c. Under 1 day: Hours / Minutes
6. DATE OF BIRTH (month day year): October 14, 1920
7a. CITY, TOWN OR LOCATION OF DEATH: Portland
7b. HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number): St. Vincent Hospital
7c. If hosp or inst, indicate DOA or Emergency (specify): Inpatient
7d. COUNTY OF DEATH: Washington
8. STATE OF BIRTH (If not in U.S.A. name country): Oregon
9. CITIZEN OF WHAT COUNTRY: USA
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
11. SPOUSE (If married, widowed or divorced): Peggy
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (specify yes or no): No
13. SOCIAL SECURITY NUMBER: [redacted]
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 804-410
14b. KIND OF BUSINESS OR INDUSTRY: Trucking
15a. RESIDENCE — STATE: Oregon
15b. COUNTY: Multnomah
15c. CITY, TOWN OR LOCATION: Portland 23
15d. STREET AND NUMBER OR R.F.D.: 3525 N. Arlington Place
15e. ZIP: 97217
15f. Inside City Limits? (specify yes or no): Yes
16. FATHER — NAME (First, middle, last): John Doug'as O'Neil
17. MOTHER — NAME (First, middle, last, if deceased, maiden name): Hilda Zollner
18. INFORMANT — NAME AND RELATIONSHIP TO DECEASED: John E. O'Neil - Son

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL, MAUSOLEUM (specify): Burial
19b. CEMETERY OR CREMATORY — NAME: Lincoln Memorial Park
19c. LOCATION — City or Town, State: Portland, Oregon
20a. FUNERAL SERVICE LICENSEE or person acting as such (Signature): Kelly Cameron
20b. NAME AND ADDRESS OF FACILITY: St. Johns Funeral Home 7525 N. Richmond, Portland, Oregon 97203

CERTIFIER

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

21a. Signature: [signature]
21b. DATE SIGNED (Mo. Day Year): September 1, 1987
21c. HOUR OF DEATH: 12:45 AM
21d. NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print): David Rullman, M.D., 2220 SW 1st, Portland, Oregon 21e. 97201
22. NAME OF ATTENDING PHYSICIAN (If other than certifier) (Type or Print):
22a. DATE RECEIVED BY REGISTRAR (Mo. Day Year): SEP 08 1987
22b. REGISTRAR (Signature): Lorraine F. Bennett

CAUSE OF DEATH

PART I
23. IMMEDIATE CAUSE (Enter only one cause per line for a, b, and c.)
a. Metastatic Brain Cancer — Interval between onset and death: 1 month
DUE TO OR AS A CONSEQUENCE OF:
b. Lung Cancer — Interval between onset and death: 1 year
DUE TO OR AS A CONSEQUENCE OF:
c. — Interval between onset and death:

PART II
24. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to death but not resulting in the underlying cause given in PART I.)
25. AUTOPSY (Specify yes or no): No
26. WAS MEDICAL EXAMINER NOTIFIED? (Specify yes or no): No
27. ACCIDENT (Specify yes or no): No
28. DATE OF INJURY (Mo. Day Year)
29. HOUR OF INJURY
30. DESCRIBE HOW INJURY OCCURRED
31. INJURY AT WORK (Specify yes or no): No
32. PLACE OF INJURY (At home, farm, street, factory, office building, etc. (Specify))
33. LOCATION — STREET OR R.F.D. NO. — CITY OR TOWN — STATE

34. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES ☐ NO ☒ N/A ☐
35. WAS GIFT MADE? YES ☐ NO ☐ N/A ☐

RESERVED FOR REGISTRAR'S USE

FILED FOR RECORD
SKAMANIA COUNTY, WASH
BY SKAMANIA CO. TITLE

REAL ESTATE EXCISE TAX

ORIGINAL - VITAL STATISTICS COPY

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PAID Exempt

SKAMANIA COUNTY TREASURER

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DEC 2 3 59 PM '92
P. Lowry
DEPUTY
GARY M. OLSON

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON STATE HEALTH DIVISION.

DATE ISSUED NOV 10 1992

EDWARD J. JOHNSON II, STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE