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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER — STATE FILE NUMBER

1 NAME — First: Ruth; Middle: ; Last: Russell				2 SEX (M / F): Female	3 DEATH DATE (Mo Day Yr): May 27, 1992		
4 AGE LAST BIRTHDAY (Yrs): 81	5 UNDER 1 YEAR Mos / Days	5 UNDER 1 DAY Hours / Mins	7 BIRTHDATE (Mo Day Yr): 6/11/10	8 BIRTHPLACE (City, State or Foreign Country): Cavendish, Idaho	9 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No): No	10 COUNTY OF DEATH: Clark	
11 CITY, TOWN OR LOCATION OF DEATH: Vancouver	12 PLACE OF DEATH (X box for place then give address or institution name): 1 ☐ Hospital 2 ☐ In Transport 3 ☐ Emerg Phys Location 4 ☐ Nursing Home 5 XX Your Home 6 ☐ Other Place: Rose Vista Nursing Home					13 EMPLOYED AT LAST 15 YEARS? (Yes / No): No	
14 MARITAL STATUS (Married, Never Married, Widowed, Divorced) (Specify): Married	15 SURVIVING SPOUSE (If wife, give maiden name): Everett Russell		16 SOCIAL SECURITY NO: [redacted]		17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs.	College (1-4 or 5+):	
18 USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED): Homemaker	19 KIND OF BUSINESS OR INDUSTRY: Home	20 Was Decedent of Hispanic origin or descent? (Ancestry) (Specify yes or no. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify: No			21 RACE (Specify): White		
22 RESIDENCE — NUMBER AND STREET: 5001 Columbia View Dr.	23 CITY/TOWN OR LOCATION: Vancouver	24 INSIDE CITY LIMITS? (Yes / No): Yes	25A COUNTY: Clark	25B LENGTH OF RES IN CO: 1 yrs	26 STATE: WA	27 ZIP CODE: 98661	
28 FATHER'S NAME — FIRST, MIDDLE, LAST: Homer Harper Michael			29 MOTHER'S NAME — FIRST, MIDDLE, MAIDEN SURNAME: Myrtle Margaret Zinn				
30 INFORMANT — NAME: Everett Russell	31 MAILING ADDRESS — STREET OR RFD NO: M.P. 34.11 SR 14	CITY OR TOWN: Skamania	STATE: WA	ZIP: 98648			
32 BURIAL, CREMATION, REMOVAL, OTHER (Specify): Cremation	33 DATE (Mo Day Yr): 5/29/92	34 CEMETERY/CREMATORY — NAME: Park Hill Crematory		35 LOCATION — CITY/TOWN, STATE: Vancouver, Washington			
36 FUNERAL DIRECTOR SIGNATURE: X [signature]	37 NAME OF FACILITY: Evergreen Staples Funeral Chapel			38 ADDRESS OF FACILITY: 4700 St. Johns Rd Vancouver, Washington 98661			

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

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] MD

40 DATE SIGNED (Mo, Day, Yr): May 28, 1992
41 HOUR OF DEATH (24 Hrs): 1315
42 NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):
46 NAME AND ADDRESS OF CERTIFIER — PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): Dr. Timothy T. Ross, M.D. 1954 Ft. Vancouver Way Vancouver, WA 98663

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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):
48 PRONOUNCED DEAD (Mo, Day, Yr):
47 HOUR PRONOUNCED DEAD (24 Hrs):
49 ME/CORONER FILE NUMBER:

FILED FOR RECORD

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

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (Final disease or condition resulting in death)	A Acute respiratory failure	1 hr.
DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. Subsequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.	DUE TO, OR AS A CONSEQUENCE OF: B Acute bacterial pneumonia	2 wks.
	DUE TO, OR AS A CONSEQUENCE OF: C	
	DUE TO, OR AS A CONSEQUENCE OF: D	

51 OTHER SIGNIFICANT CONDITIONS — CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE: Alzheimers dementia, dysphagia.
52 AUTOPSY? (Yes / No):
53 WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No):

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 DATE RECEIVED BY REGISTRAR (Mo, Day, Yr): MAY 2 8 1992
62 REGISTRAR SIGNATURE: X [signature] Karen Steingart, MD
DATE:

Registered
Indexed, Dir
Indirect
Filmed
Mailed

DOH 110-008 (Rev 7/91) (formerly DSHS 9-150)
A
DOH 01-003 (7/89)

HEALTH DISTRICT — STATE OF WASHINGTON — NO. 01

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH VITAL RECORDS. CERTIFIED COPIES MUST HAVE THE OFFICIAL SEAL

CERTIFIED

MAY 2 8 1992

Karen Steingart
Dr. Karen Steingart
Health District Officer
S.W. Wash. Health Dist.

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