CERTIFICATION OF VITAL RECORD

168853C (1)

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

BOOK 136 PAGE 832

D-6720 ID TAG NO.

116771 — 0083 (Local File Number) — 136 — 93 000588 (State File Number)

1. DECEDENT'S NAME (First / Middle / Last)			2. SEX	3. DATE OF DEATH (Month, Day, Year)
Donald	Lee	MAY	Male	January 3, 1993

4. SOCIAL SECURITY NUMBER	5a. AGE (Last Birthday) (Years)	5b. Under 1 Year (Mos. / Days)	5c. Under 1 Day (Hours / Mins.)	6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Month, Day, Year)
[redacted]	57			Great Falls, MT	December 22, 1935

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

9a. PLACE OF DEATH (Check only one): ☐ HOSPITAL: X Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Bess Kaiser Medical Center	Portland	Multnomah

10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	10b. KIND OF BUSINESS/INDUSTRY	11. MARITAL STATUS (Married, Never Married, Widowed, Divorced (Specify))	12. SPOUSE (If Married, Widowed, Divorced)
Pharmacist	Pharmaceutical Sales	Married	Marie May

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Washington	Clark	Battle Ground	10438 NE 219th Street

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 X No	98604	☐ Yes X No (Specify)	White	5½

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden)	19. INFORMANT'S NAME and relationship to deceased
Cyril Sargent May	Charlotte Young	Marie May - 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)	Park Hill Crematory	Vancouver, Washington

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	21b. LICENSE NUMBER (Of Licensee)	22. NAME, ADDRESS AND ZIP OF FACILITY
Dexter F. Hartke	1397	Layne's Funeral Home 16 N. Clark Ave., (P.O. Box 7) Battle Ground, Washington 98604

23. DATE FILED (Month, Day, Year): JAN 14 1993

24. REGISTRAR'S SIGNATURE: Edward W. Bloom

25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT?	26. WAS GIFT MADE?
X Yes ☐ No ☐ N/A	☐ Yes X No ☐ N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH	28. WAS MEDICAL EXAMINER NOTIFIED?
10:40 PM	☐ Yes XX 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: Steward Levy
31. DATE SIGNED (Month, Day, Year): 1-6-93

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH	31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour)
M	M

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.
(Signature)
33. DATE SIGNED (Month, Day, Year) COUNTY

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print)
Steward Levy, MD, 2211 E. Hill Pain Blvd., Vancouver, Washington 98661

35. NAME OF ATTENDING PHYSICIAN (IF OTHER THAN CERTIFIER) (Type or Print)
TOM SYLTEBO, M.D.

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

		Interval between onset and death
PART I a.	Congestive Heart Failure	
	DUE TO OR AS A CONSEQUENCE OF:	
b.	Cor Pulmonale	Interval between onset and death
	DUE TO OR AS A CONSEQUENCE OF:	
c.	COPD	Interval between onset and death
PART II	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 X No	☐ Yes ☐ No

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

RESERVED FOR REGISTRAR'S USE

15963
REAL ESTATE EXCISE TAX
JUL 19 1993
PAID Exempt
By Deputy
CLARK COUNTY TREASURER

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.

MAR 16 1993
DATE ISSUED

Edward J. Johnson II
EDWARD J JOHNSON II,
STATE REGISTRAR

Registered
Amended, Dir
Signed
Filed
Mailed

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

CERTIFICATION OF VITAL RECORD

168 8 53 CC (1)

OREGON HEALTH DIVISION
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CERTIFICATE OF DEATH

BOOK 136 PAGE 832

D-6720 ID TAG NO. 116771 Local File Number — 0083

136- 93-000588 State File Number

1 DECEDENT'S NAME: First: Donald	Middle: Lee	Last: MAY	2 SEX: Male	3 DATE OF DEATH (Month, Day, Year): January 3, 1993	
4 SOCIAL SECURITY NUMBER: 535-34-3695	5a AGE (Last Birthday): 57	5b Under 1 Year: Months / Days	5c Under 1 Day: Hours / Minutes	6 BIRTHPLACE (City and State or Foreign Country): Great Falls, MT	7 DATE OF BIRTH (Month, Day, Year): December 22, 1935

8 WAS DECEDENT EVER IN U.S. ARMED FORCES? [ ] Yes [X] No

8a PLACE OF DEATH (Check only one): [X] Hospital (Inpatient / ER/Outpatient / DOA) [ ] Other (Nursing Home / Decedent's Home / Other (Specify))

8b FACILITY NAME (If not institution, give street and number): Boss Kaiser Medical Center	8c CITY, TOWN OR LOCATION OF DEATH: Portland	8d COUNTY OF DEATH: Multnomah

9a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pharmacist	9b KIND OF BUSINESS/INDUSTRY: Pharmaceutical Sales	11 MARITAL STATUS (Married, Never Married, Widowed, Divorced (Specify)): Married	12 SPOUSE (If Married, Widowed): Marie May

13a RESIDENCE - STATE: Washington	13b COUNTY: Clark	13c CITY, TOWN OR LOCATION: Battle Ground	13d STREET AND NUMBER: 10438 NE 219th Street

13e INSIDE CITY LIMITS? [ ] Yes [X] No	13f ZIP CODE: 98604	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [X] No [ ] Yes Specify:	15 RACE - American Indian, Black, White, etc. (Specify): White	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12):	College (1-4 or 5+): 5+

17 FATHER - NAME first middle last: Cyril Sargent May	18 MOTHER - NAME first middle maiden: Charlotte Young	19 INFORMANT - NAME and relationship to deceased: Marie May - Wife

20a METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	20b PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Park Hill Crematory	20c LOCATION - City or Town, State: Vancouver, Washington

21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Dexter F. Hartke	21b LICENSE NUMBER (Of Licensee): 1397	22 NAME, ADDRESS AND ZIP OF FACILITY: Layne's Funeral Home, 16 N. Clark Ave., (P.O. Box 7), Battle Ground, Washington 98604

23 DATE FILED (Month, Day, Year): JAN 11 1993

24 REGISTRAR'S SIGNATURE: Otto W. Blom

25 DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? [X] YES [ ] NO [ ] N/A

26 WAS GIFT MADE? [ ] YES [X] NO [ ] N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27 TIME OF DEATH: 10:40 PM	28 WAS MEDICAL EXAMINER NOTIFIED? [ ] Yes [XX] No

29 To the best of my knowledge, death occurred at the time, date, place and due to the causes and manner stated. Signature: Steward Levy

30 DATE SIGNED (Month, Day, Year): 1-6-93

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a TIME OF DEATH: M	31b DATE PRONOUNCED DEAD (Month, Day, Year, Hour): M

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. (Signature)

33 DATE SIGNED (Month, Day, Year) COUNTY

34 NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Steward Levy, MD, 2211 E. Mill Pain Blvd., Vancouver, Washington 98661

35 NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print): TOM SYLTEBO M.D.

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. Interval between onset and death

PART I
(a) Congestive Heart Failure
DUE TO OR AS A CONSEQUENCE OF:
(b) Cor Pulmonale
DUE TO OR AS A CONSEQUENCE OF:
(c) COPD

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

37 Did tobacco use contribute to the death? [ ] Yes [ ] No [ ] Probably [ ] Unk	38 AUTOPSY [ ] Yes [X] No	39 Were findings considered in determining cause of death? [ ] Yes [ ] No	

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

RESERVED FOR REGISTRAR'S USE

15963 REAL ESTATE EXCISE TAX

JUL 19 1993

PAID Exempt

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.

SKAMANIA COUNTY TREASURER

MAR 16 1993

DATE ISSUED

Edward J. Johnson II
EDWARD J. JOHNSON II,
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

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

JUL 19 3 30 PM '93

P. Lowry
AUDITOR
GARY M. OLSON