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

116869 — 04890 ID TAG NO — 121-86 Local File Number

BOOK 137 PAGE 55

CERTIFICATE OF DEATH

State File Number

TYPE OR PRINT IN PERMANENT BLACK INK. FOR INSTRUCTIONS SEE HANDBOOK

DECEDENT

DEATH OCCURRED IN INSTITUTION (HANDBOOK REGARDING COMPLETION OF THESE ITEMS)

1 DECEASED — NAME (First / Middle / Last)	Gordon	Clarence	BAKER	
2 DATE OF DEATH (month, day, year)	October 27, 1986			
3 RACE (White, Black, American Indian, etc.) (specify)	White			
4 SEX	Male			
5a AGE — Last birthday (years)	86			
5b Under 1 year: months / days				
5c Under 1 day: hours / min				
6 DATE OF BIRTH (month, day, year)	September 27, 1900			
7a CITY, TOWN OR LOCATION OF DEATH	Hood River			
7b HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number)	Hood River Care Center			
7c If HOSP. OR INST. Indicate DOA, OP, Emer. Rm., Inpatient (specify)	Inpatient			
7d COUNTY OF DEATH	Hood River			
8 STATE OF BIRTH (If not in U.S.A. name country)	Illinois			
9 CITIZEN OF WHAT COUNTRY	U.S.A.			
10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	Married			
11 SPOUSE (IF MARRIED, WIDOWED)	Sarah E.			
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)	Farmer			
14b KIND OF BUSINESS OR INDUSTRY	Agriculture			
15a RESIDENCE — STATE	Washington			
15b COUNTY	Skamania			
15c CITY, TOWN OR LOCATION	Underwood			
15d STREET AND NUMBER OR R.F.D.	Star Route Box 128			
ZIP	98651			
15e Inside City Limits (specify yes or no)	No			
16 FATHER — NAME (first, middle, last)	Charles - Baker			
17 MOTHER — (first, middle, last) (Maiden Name)	Cora - Rice			
18 INFORMANT — NAME and relationship to deceased	Betty Baker, Wife			
19a BURIAL, CREMATION, REMOVAL, MAUS (specify)	Rem/Burial			
19b CEMETERY OR CREMATORY — NAME	Klickitat County Dist. #1			
19c LOCATION (city or town, state)	White Salmon, WA			
20a FUNERAL SERVICE LICENSEE or person acting as such (Signature)	Teresa L. Gardner			
20b NAME AND ADDRESS OF FACILITY	GARDNER FUNERAL HOME, INC. White Salmon, WA			

POSITION

1 ——
2 ——
3 ——

CERTIFIER

* To be Completed by CERTIFYING PHYSICIAN Only

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

21a (Signature) ► [signature] MD — 21b DATE SIGNED (Mo., Day, Year): 10.29.86 — 21c HOUR OF DEATH: 2050 M

21d NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print): John Kaiser, M.D. Family Health Center White Salmon, WA 98672 ZIP

21e NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

22a DATE RECEIVED BY REGISTRAR (Mo., Day, Year): OCT 30 1986 — 22b REGISTRAR (Signature) ► [signature]

ADDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE (A) ENDING THE UNDERLYING CAUSE LAST

4 ——
5 ——
6 ——

USE OF DEATH

PART I

23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)

(a) cardiopulmonary arrest — Interval between onset and death: 4 min

DUE TO OR AS A CONSEQUENCE OF

(b) renal failure — Interval between onset and death: 2 wks.

DUE TO, OR AS A CONSEQUENCE OF

(c) — Interval between onset and death

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

AUTOPSY (Specify Yes or No)	24 No	WAS MEDICAL EXAMINER NOTIFIED (Specify Yes or No)	25 No	
ACCIDENT (Specify Yes or No)	26a No	DATE OF INJURY (Mo., Day, Year)	26b	HOUR OF INJURY 26c M
DESCRIBE HOW INJURY OCCURRED	26d			
INJURY AT WORK (Specify Yes or No)	26e No	PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f	LOCATION — STREET OR R.F.D. NO. — CITY OR TOWN — STATE 26g

DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES ☐ NO ☐ N/A ☒

WAS GIFT MADE? YES ☐ NO ☐

RESERVED FOR REGISTRAR'S USE

FILED FOR RECORD
SKAMANIA CO. WASH
BY David C. Baker

ORIGINAL–VITAL STATISTICS COPY

45-2 Rev. 1-86

Aug 2 11 51 AM '93
P. Lowry
AUDITOR
GARY M. OLSON

STATE OF OREGON
COUNTY OF HOOD RIVER

This certifies that the foregoing is a correct and complete transcript of a record of death on file with the HOOD RIVER COUNTY PUBLIC HEALTH DEPARTMENT.

[signature]
County Registrar of Vital Statistics

October 30, 1986
Date

NOT VALID WITHOUT RAISED SEAL OF HOOD RIVER COUNTY HEALTH DEPARTMENT

Registered
Indexed, Dir
Indirect
Filmed
Mailed

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DECEDENT

1 DECEASED — NAME (First, Middle, Last): Gordon Clarence BAKER

2 DATE OF DEATH (month, day, year): October 27, 1986

3 RACE (White, Black, American Indian, etc.) (Specify): White

4 SEX: Male

5a AGE — Last birthday (years): 86

5b Under 1 year — months / days

5c Under 1 day — hours / min

6 DATE OF BIRTH (month, day, year): September 27, 1900

7a CITY, TOWN OR LOCATION OF DEATH: Hood River

7b HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number): Hood River Care Center

7c IF HOSP. OR INST. Inpatient or DOA, OP/Emer Rm., Inpatient (Specify): Inpatient

7d COUNTY OF DEATH: Hood River

8 STATE OF BIRTH (If not in U.S.A., name country): Illinois

9 CITIZEN OF WHAT COUNTRY: U.S.A.

10 MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

11 SPOUSE (IF MARRIED, WIDOWED): Sarah E.

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): Farmer

14b KIND OF BUSINESS OR INDUSTRY: Agriculture

15a RESIDENCE — STATE: Washington

15b COUNTY: Skamania

15c CITY, TOWN OR LOCATION: Underwood

15d STREET AND NUMBER OR R.F.D.: Star Route Box 128

ZIP: 98651

15e Inside City Limits (Specify yes or no): No

16 FATHER — NAME first middle last: Charles - Baker

17 MOTHER — NAME first middle last (Maiden Name): Cora - Rice

18 INFORMANT — NAME and relationship to deceased: Betty Baker, Wife

DISPOSITION

19a BURIAL, CREMATION, REMOVAL, OTHER (Specify): Rem/Burial

19b CEMETERY OR CREMATORY — NAME: Klickitat County Dist. #1

19c LOCATION (city or town, state): White Salmon, WA

20a FUNERAL SERVICE LICENSEE or person acting as such (Signature): Leon L. Duncan

20b NAME AND ADDRESS OF FACILITY: GARDNER FUNERAL HOME, INC. White Salmon, WA

CERTIFIER

To Be Completed By CERTIFYING PHYSICIAN Only

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

21a (Signature): John Kaiser MD

21b DATE SIGNED (Mo., Day, Year): 10-29-86

21c HOUR OF DEATH: 2050 M

21d NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print): John Kaiser, M.D. Family Health Center White Salmon, WA 98672 ZIP

21e NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print):

21f

22a DATE RECEIVED BY REGISTRAR (Mo., Day, Year): OCT 30 1986

22b REGISTRAR (Signature): Barbara Judd

CAUSE OF DEATH

PART I — 23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)

(a) cardiopulmonary arrest — Interval between onset and death: 4 min

DUE TO, OR AS A CONSEQUENCE OF:

(b) renal failure — Interval between onset and death: 2 wks.

DUE TO, OR AS A CONSEQUENCE OF:

(c) — Interval between onset and death:

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

24 AUTOPSY (Specify Yes or No): No

25 WAS MEDICAL EXAMINER NOTIFIED? (Specify Yes or No): No

26a ACCIDENT (Specify Yes or No): No

26b DATE OF INJURY (Mo., Day, Year)

26c HOUR OF INJURY M

26d DESCRIBE HOW INJURY OCCURRED

26e INJURY AT WORK (Specify Yes or No): No

26f PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26g LOCATION — STREET OR R.F.D. NO. — CITY OR TOWN — STATE

27a DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? YES ☐ NO ☐ N.A. ☒

27b WAS GIFT MADE? YES ☐ NO ☐

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This certifies that the foregoing is a correct and complete transcript of a record of death on file in the HOOD RIVER COUNTY PUBLIC HEALTH DEPARTMENT.

Barbara Judd
County Registrar of Vital Statistics

October 30, 1986
Date

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