STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF HEALTH

VITAL RECORDS

LOCAL FILE NUMBER 116994 **CERTIFICATE OF DEATH** BOOK 137 PAGE 340

DECEDENT

1. NAME (First, Middle, Last)	2. SEX	3. DATE OF DEATH (Mo, Day, Yr)	STATE FILE NUMBER
William W. NELSON	Male	08 Apr 1989	146

4. AGE (Last Birthday)	5. UNDER 1 YEAR	6. UNDER 1 DAY	7. DATE OF BIRTH (Mo, Day, Yr)	8. BIRTHPLACE (State or USA Possession)	9. CITIZEN OF WHAT COUNTRY	10. COUNTY OF DEATH
78			3/16/1911	Washington	U.S.A.	Clark

11. CITY, TOWN, OR LOCATION OF DEATH	12. PLACE OF DEATH (Enter only one: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Other 5 Nursing Home 6 Residence)	13. WORKED IN LAST 5 YEARS?
Vancouver	Highland Terrace Nursing Home	Yes

14. MARITAL STATUS	15. SURVIVING SPOUSE (If wife, give maiden name)	16. WAS DECEDENT EVER IN U.S. ARMED FORCES?	17. SOCIAL SECURITY NO.	18. HIGH SCHOOL GRADUATE?
Married	Phyllis M. Krause	No	[redacted]	No

19. USUAL OCCUPATION	20. KIND OF BUSINESS/INDUSTRY	21. WAS DECEDENT OF HISPANIC ORIGIN?	22. RACE	
Powerhouse Operator	Corps of Engineers	No	Yes	White

23. RESIDENCE (Number and Street)	24. CITY, TOWN, OR LOCATION	25. INSIDE CITY LIMITS?	26. COUNTY	27. STATE	28. ZIP CODE
P.O. Box 414	Stevenson	Yes	Skamania	Washington	98648

PARENTS

29. FATHER'S NAME (First, Middle, Last)	30. MOTHER'S NAME (First, Middle, Maiden Surname)
Frank B. Nelson	Mabel - Butts

31. INFORMANT — NAME	32. MAILING ADDRESS (Street or RFD No, City or Town, State, Zip)
Phyllis Nelson	P.O. Box 414 Stevenson, WA 98648

DISPOSITION

33. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34. DATE (Mo, Day, Yr)	35. CEMETERY OR CREMATORY — NAME	36. LOCATION — CITY, TOWN, STATE
Burial	4/12/89	Stevenson Cemetery	Stevenson, WA

37. FUNERAL DIRECTOR SIGNATURE	38. NAME OF FACILITY	39. ADDRESS OF FACILITY (Street or RFD No, City or Town, State, Zip)
X R. Pollenick	GARDNER FUNERAL HOME, INC.	Box 390 White Salmon, WA 98672

CERTIFIER

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

40. TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED

SIGNATURE AND TITLE: X Thomas A Lorence

42. DATE SIGNED (Mo, Day, Yr)	43. HOUR OF DEATH (24 Hr)
4/14/89	1305

44. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

41. ON THE BASIS OF EXAMINATION AND OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED

SIGNATURE AND TITLE: X

45. DATE SIGNED (Mo, Day, Yr)	46. HOUR OF DEATH (24 Hr)

47. PRONOUNCED DEAD (Mo, Day, Yr) | 48. HOUR PRONOUNCED DEAD (24 Hr)

49. NAME AND ADDRESS OF CERTIFIER — PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)

Dr. Lorence 19500 SE Stark Portland, OR 97233

CAUSE OF DEATH

50. PART I ENTER THE DISEASES, INJURIES OR COMPLICATIONS WHICH CAUSED THE DEATH. DO NOT ENTER THE MODE OF DYING SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE.

IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST

		Interval between onset and death
(a)	Chronic Obstructive Pulmonary Disease	1 year
(b) DUE TO OR AS A CONSEQUENCE OF	Emphysema	Interval between onset and death
(c) DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death

51. OTHER SIGNIFICANT CONDITIONS — CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE

52. AUTOPSY? (Yes, No)	53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes, No)
No	No

54. ACC, SUICIDE, HOMICIDE, UNDET OR PENDING INVEST (Specify)	55. INJURY DATE (Mo, Day, Yr)	56. HOUR OF INJURY (24 Hr)	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. REGISTRAR SIGNATURE	62. DATE RECEIVED (Mo, Day, Yr)
X Karen Steingart, MD	APR 24 1989

DSHS 9-150 (Rev. 1-89) -1187-

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APR 24 1989

Karen Steingart, MD

KAREN STEINGART, M.D.
DISTRICT HEALTH OFFICER

SEAL

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REAL ESTATE EXCISE TAX
AUG 12 1993
PAID Exempt

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

After Recording Return to:

James Nelson
P.O. Box 276
Hood River, OR 97031

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AUDITOR
GARY M. OLSON