STATE OF WASHINGTON
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

LOCAL FILE NUMBER 117212

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STATE FILE NUMBER

DECEDENT

1. NAME – FIRST, MIDDLE, LAST			2. SEX	3. DEATH DATE (Mo., Day, Yr.)
GLEN	DALE	SINCLAIR	Male	Apr. 20, 1991

4. AGE LAST BIRTHDAY (Yrs)	5. UNDER 1 YEAR: MONTHS	DAYS	6. UNDER 1 DAY: HOURS	MINS	7. DATE OF BIRTH (Mo., Day, Yr.)	8. BIRTHPLACE (State or USA geography)	9. CITIZEN OF WHAT COUNTRY	10. COUNTY OF DEATH
68					Nov. 19, 1922	California	U.S.A.	Clark

11. CITY, TOWN OR LOCATION OF DEATH	12. PLACE OF DEATH – HOSPITAL: Inpatient, ER, Outpatient, or Dead on Arrival; NURSING HOME; RESIDENCE; OTHER PLACE	13. SERVED IN U.S. ARMED FORCES? (Yes or No)
Vancouver	Southwest Washington Med. Ctr. Campus	No

14. MARITAL STATUS – Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (If wife, give maiden name)	16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)	17. SOCIAL SECURITY NO.	18. HIGH SCHOOL GRADUATE? (Yes or No)
Married	Katherine Chinakos	Yes	[redacted]	Yes

19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)	20. KIND OF BUSINESS/INDUSTRY	21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	22. RACE (White, Black, American Indian, Asian or Pacific Islander, etc.)
Ret. Chief of Police	Police Department	No	White

23. RESIDENCE – NUMBER AND STREET	24. CITY, TOWN OR LOCATION	25. INSIDE CITY LIMITS? (Yes or No)	26. COUNTY	27. STATE	28. ZIP CODE
2702 S. W. 6th Ave.	Camas	Yes	Clark	Washington	98607

PARENTS

29. FATHER'S NAME – FIRST, MIDDLE, LAST	30. MOTHER'S NAME – FIRST, MIDDLE, MAIDEN SURNAME
Glen Elder Sinclair	Frances Gordon

31. INFORMANT – NAME	32. MAILING ADDRESS (STREET OR RFD NO., CITY OR TOWN, STATE, ZIP)
Katherine Sinclair - Wife	2702 S. W. 6th Ave., Camas, Washington 98607

DISPOSITION

33. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	34. DATE (Mo., Day, Yr.)	35. CEMETERY OR CREMATORY – NAME	36. LOCATION – CITY/TOWN, STATE
Burial	Apr. 24, 1991	Rose City Cemetery	Portland, Oregon

37. FUNERAL DIRECTOR – SIGNATURE	38. NAME OF FACILITY	39. ADDRESS OF FACILITY
X Lyle E. Smith	Straub's Funeral Home	Camas, Washington

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 M. Lavelle MD

42. DATE SIGNED (Mo., Day, Yr.) 4/23/91

43. HOUR OF DEATH (24 Hrs) 2307

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

48. NAME AND ADDRESS OF CERTIFIER – PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)
M. Lavelle, M.D. - 602 N. E. 92nd Ave., Vancouver, Washington 98664

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

44. DATE SIGNED (Mo., Day, Yr.)

45. HOUR OF DEATH (24 Hrs)

47. PRONOUNCED DEAD (Mo., Day, Yr.)

49. HOUR PRONOUNCED DEAD (24 Hrs)

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)	(a) Cerebral Vascular Accident	INTERVAL BETWEEN ONSET AND DEATH
Sequentially 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)	INTERVAL BETWEEN ONSET AND DEATH
	DUE TO, OR AS A CONSEQUENCE OF (c)	INTERVAL BETWEEN ONSET AND DEATH

51. OTHER SIGNIFICANT CONDITIONS – CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE: Hypertensive Heart Disease

52. AUTOPSY? (Yes or No): No

53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes or No)

54. ACC., SUICIDE, HOMICIDE, 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 or No)	59. PLACE OF INJURY – AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (Specify)	60. LOCATION – STREET OR RFD NO., CITY/TOWN, STATE
		FILED FOR RECORD SKAMANIA CO. WASH BY SKAMANIA CO. TITLE

61. REGISTRAR SIGNATURE
X Karen Steingart, mad

62. DATE RECEIVED (Mo., Day, Yr.) APR 2 6 1991

DOH 110-008 (Rev. 8/89) (formerly DSHS 9-150)

RECORDER'S NOTE:
NOT AN ORIGINAL DOCUMENT

016072

Ind 2-22-93

REAL ESTATE EXCISE TAX

APR 2 6 1991

SEP 02 1993

PAID Exempt
JW

SEAL

SKAMANIA COUNTY TREASURER

SEP 2 2 22 PM '93

P. Lowry
AUDITOR
GARY H. OLSON

Karen Steingart, mad.

KAREN STEINGART, M.D.
HEALTH DISTRICT OFFICER

Registered
Indexed, Dir
Indirect
Filed
Mailed

DOH 01-003 (7/89)