STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Health

574 LOCAL FILE NUMBER

122144 **CERTIFICATE OF DEATH**

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BOOK 149 STATE FILE NUMBER PAGE 471

1. Name (First, Middle, Last): Evelyn Marie AMUNDSON
2. Sex (M/F): Female
3. Death date (Mo, Day, Yr): April 23, 1993
4. Age last birthday (Yrs): 71
7. Birthdate (Mo, Day, Yr): Apr.25,1921
8. Birthplace (City, State or Foreign Country): Sagle, 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: Highland Terrace Nursing Home
13. Smoking in last 15 years? (Yes/No): yes
14. Marital status: Widowed
15. Surviving spouse:
16. Social Security No.: 536-22-0369
17. Decedent's education: 9
18. Usual occupation: Homemaker
19. Kind of business or industry: Own Home
20. Was decedent of Hispanic origin or descent? (Yes/No): no
21. Race: White
22. Residence—number and street: 2946 E. 1st. Ave.
23. City/town or location: Camas
24. Inside city limits? (Yes/No): yes
25. County: Clark
26. Length of residence in county: 23yrs
27. State: WA.
28. Zip code: 98607
29. Father's name: Archie Oral Irish
30. Mother's name: Odell C. Eilertsen
31. Informant—name: Leonard Parrish
32. Mailing address: 9223 Muroc St. Bellflower CA. 90706
33. Burial, cremation, removal, other: Burial
34. Date: Apr.28,1993
35. Cemetery/crematory—name: Evergreen Memorial Garden
36. Location—city/town, state: Vancouver, WA.
37. Funeral director signature: X [signature]
38. Name of facility: Memorial Gardens Mortuary
39. Address of facility: 1101 NE 112th Ave Vancouver, WA. 98684

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN

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

Date signed (Mo, Day, Yr): 4-26-93

Hour of death (24 Hrs.): 1912

Name and title of attending physician if other than certifier:

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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

FILED FOR RECORD
SKAMANIA CO. WASH
BY SKAMANIA CO. TITLE
APR 24 2 44 PM '95
P. Lowry
AUDITOR
GARY H. OLSON

Name and address of certifier: Timothy Ross M.D. 9991 NW Hoge Portland OR. 97231

Enter the diseases, injuries, or complications which caused the death.

	Cause	Interval between onset and death
Immediate cause A.	Acute respiratory failure	1 hr.
Due to, or as a consequence of B.	Acute aspiration pneumonia	5 hrs.
Due to, or as a consequence of C.		
Due to, or as a consequence of D.		

Other significant conditions: Bronchogenic carcinoma with pleural effusion

Autopsy? (Yes/No): no

Was case referred to medical examiner or coroner? no

Registered ✓
Indexed ✓
Indirect ✓
Filmed
Mailed

Record amendment:

Registrar signature: [signature] MD

Date received: APR 2 8 1993

SEAL OF THE STATE OF WASHINGTON 1889

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

DOH 110-003 A

DOH 01-003

CERTIFIED

APR 28 1993

[signature]
Dr. Karen Steingart
Health District Officer
S.W. Wash. Health Dist.

AA250522