

FILED FOR RECORD  
SKAMANIA CO. WASH  
BY *Dorothea Roberts*  
Dec 13, 10 59 AM '95  
AUDITOR  
GARY M. OLSON

124004 Declaration of Heirship, Inheritance, Domicile and Indemnity Agreement

BOOK 154 PAGE 150

STATE OF WASHINGTON )  
                                  ) ss.  
County of Skamania )

I, DOROTHEA A. ROBERTS residing at 72 Wedrick Rd., Stevenson, Skamania County, Washington, being first duly sworn, depose and say as follows:

1. WILLIS D. ROBERTS died intestate in Klickitat County, Washington on March 5, 1995.
2. At the time of his death, WILLIS D. ROBERTS was married to DOROTHEA A. ROBERTS.
3. The sole surviving heirs at law of WILLIS D. ROBERTS are DOROTHEA A. ROBERTS, RUSSELL D. ROBERTS, CHARLES L. ROBERTS, CHARLOTTE A. FELLER and SHIRLEY J. STEVENS. The deceased, WILLIS D. ROBERTS, left no children or children of children who predeceased him other than those named herein.
4. The expenses of the last illness and burial of WILLIS D. ROBERTS and all other claims against the decedent's estate have been settled and paid.
5. There are no Federal Estate taxes due or Washington inheritance taxes due.
6. The purpose of this affidavit is to induce Skamania County Title Company to accept such affidavit in forbearance of a demand made by said title insurance company to probate the decedent's estate.
7. At the time of the decedent's death, decedent owned property in Stevenson, Skamania County, Washington, located at 72 Wedrick Road, and described as follows:

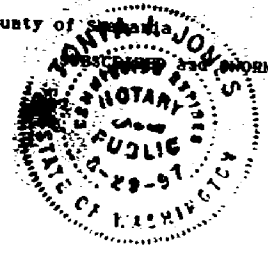
Lot 3 of the Shirley Stevens Short Plat, recorded at Skamania County, Washington Auditor's File No. 109448, Volume 119, at pages 356-357.

8. I, by my signature hereto, agree to indemnify and hold harmless Skamania County Title Company from any and all liability, obligations, expenses, legal fees or litigation costs which it may incur as a result of a falsity or inaccuracy of any statement contained in this affidavit.

DATED this 30<sup>th</sup> day of November, 1995.

*Dorothea Roberts*  
DOROTHEA A. ROBERTS

STATE OF WASHINGTON )  
County of Skamania ) ss.



Subscribed and sworn to before me this 30<sup>th</sup> day of November, 1995.

Subscribed   
Indirect   
Filed   
Mailed

*James J. Jones*  
Notary Public, for Washington  
residing at *Carson*  
My commission expires 2-29-97

*sw*

STATE OF WASHINGTON  
DEPARTMENT OF HEALTH

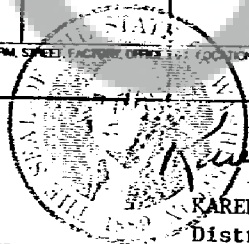
Health

CERTIFICATE OF DEATH

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1. NAME First Middle Last <b>Willis Dell ROBERTS</b>		2. SEX (M / F) <b>Male</b>		3. DEATH DATE (Mo, Day, Yr) <b>March 5 1995</b>	
4. AGE LAST BIRTHDAY (Mo, Day, Yr) <b>83</b>		5. UNDER 1 YEAR MOS DAYS		6. UNDER 1 DAY HOURS MINS	
7. BIRTHDATE (Mo, Day, Yr) <b>June 9 1911</b>		8. BIRTHPLACE State or Foreign Country <b>Groversville NY</b>		9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No) <b>No</b>	
10. COUNTY OF DEATH <b>Klickitat</b>		11. CITY, TOWN OR LOCATION OF DEATH <b>White Salmon</b>		12. PLACE OF DEATH-SEE BOOK FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME <input type="checkbox"/> HOME <input type="checkbox"/> IN TRANSPORT <input checked="" type="checkbox"/> EMERG ROOM/PTN <input type="checkbox"/> HOSP <input type="checkbox"/> NUR HOME <input type="checkbox"/> OTHER PLACE <b>Skyline Hospital</b>	
13. SMOKING IN LAST 15 YEARS? (Yes / No) <b>No</b>		14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) <b>Married</b>		15. SURVIVING SPOUSE (If wife, give maiden name) <b>Dorothea A Swartwood</b>	
16. SOCIAL SECURITY NO [REDACTED]		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (K-12) <b>10</b> College (11-16 or 17)		18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) <b>Maintenance/Trimmer</b>	
19. KIND OF BUSINESS OR INDUSTRY <b>Sawmill</b>		20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify <b>NO</b>		21. RACE (Specify) <b>White</b>	
22. RESIDENCE—NUMBER AND STREET <b>72 Wedrick</b>		23. CITY/TOWN OR LOCATION <b>Stevenson</b>		24. INSIDE CITY (L.S. 157) <b>10</b>	
25A. COUNTY <b>Skamania</b>		25B. LENGTH OF RES. IN CO <b>19 yrs</b>		26. STATE <b>Washington</b>	
27. ZIP CODE <b>98648</b>		28. FATHER'S NAME—FIRST, MIDDLE, LAST <b>Delbert D Roberts</b>		29. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME <b>Charlotte Nellie Downs</b>	
30. INFORMANT—NAME <b>Dorothea A Roberts</b>		31. MAILING ADDRESS—STREET OR RFD NO CITY OR TOWN STATE ZIP <b>72 Wedrick Stevenson WA 98648</b>		32. BURIAL CREMATION (Type of Disposition) <b>Burial</b>	
33. DATE (Mo, Day, Yr) <b>March 9 1995</b>		34. CEMETERY/CREMATORY—NAME <b>Berge Cemetery</b>		35. LOCATION—CITY/TOWN STATE <b>Home Valley WA</b>	
36. FUNERAL DIRECTOR SIGNATURE <i>C. M. [Signature]</i>		37. NAME OF FACILITY <b>GARDNER FUNERAL HOME INC.</b>		38. ADDRESS OF FACILITY—POB 390 WHITE SALMON WA 98672	
39. TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN			40. TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER		
41. 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 <i>[Signature]</i> MD			42. 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 <i>[Signature]</i>		
43. DATE SIGNED (Mo, Day, Yr) <b>3-7-95</b>		44. HOUR OF DEATH (24 Hrs) <b>1840</b>		45. DATE SIGNED (Mo, Day, Yr)	
46. HOUR OF DEATH (24 Hrs)		47. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) <b>J. Buchanan, MD</b>		48. HOUR PRONOUNCED DEAD (24 Hrs)	
49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) <b>Gary Regalbuto, MD 1410 May St. Hood River, OR 97031</b>		49. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH		49. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH	
50. IMMEDIATE CAUSE (Final disease or condition resulting in 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. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.		A. <b>Chronic Obstructive Pulmonary Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
B. <b>Consecutive Heart Failure</b>		C. <b>Consecutive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH	
D. <b>Consecutive Heart Failure</b>		D. <b>Consecutive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH	
51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE. <b>Consecutive Heart Failure</b>		52. AUTOPSY? (Yes / No) <b>No</b>		53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No) <b>No</b>	
54. ACC. SUICIDE, HOMIC. 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 / No)		59. PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE, BLDG. ETC. (Specify)	
60. LOCATION—STREET OR RFD NO, CITY/TOWN STATE		60. LOCATION—STREET OR RFD NO, CITY/TOWN STATE		60. LOCATION—STREET OR RFD NO, CITY/TOWN STATE	

SEAL



Karen R. Steingart, M.D.  
District Health Officer

DOH 01-003 (5-92)

THIS IS A CERTIFIED COPY OF THE RECORDS ON FILE WITH CENTER FOR HEALTH STATISTICS. CERTIFIED COPIES MUST MAKE THE OFFICIAL SEAL.



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH

**CERTIFICATE OF DEATH**

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1. NAME First Middle Last <b>Wills Dell ROBERTS</b>		2. SEX (M / F) <b>Male</b>	3. DEATH DATE (Mo, Day, Yr) <b>March 5 1995</b>
4. AGE LAST BIRTHDAY (Mo, Day, Yr) <b>83</b>	5. UNDER 1 YEAR MOSE DAYS	6. UNDER 1 DAY HOURS MINS	7. BIRTHDATE (Mo, Day, Yr) <b>June 9 1911</b>
8. BIRTHPLACE (City, State or Foreign Country) <b>Gloversville NY</b>		9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No) <b>No</b>	10. COUNTY OF DEATH <b>Klickitat</b>
11. CITY, TOWN OR LOCATION OF DEATH <b>White Salmon</b>		12. PLACE OF DEATH—SEE BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1. HOME 2. IN TRANSIT 3. X EMER. HOSP. 4. HOSP. 5. IN HOME 6. OTHER PLACE <b>Skyline Hospital</b>	
13. SMOKING IN LAST 15 YEARS? (Yes / No) <b>No</b>		14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) <b>Married</b>	
15. SURVIVING SPOUSE (If wife, give maiden name) <b>Dorothea A Swartwood</b>		16. SOCIAL SECURITY NO. [REDACTED]	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary (K-8) [REDACTED] College (14 or 16)
18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) <b>Maintenance/Trimmer</b>		19. KIND OF BUSINESS OR INDUSTRY <b>Sawmill</b>	
20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify <b>No</b>		21. RACE (Specify) <b>White</b>	
22. RESIDENCE—NUMBER AND STREET <b>72 Wedrick</b>		23. CITY/TOWN OR LOCATION <b>Stevenson</b>	24. INSIDE CITY LIMITS? (Yes / No) <b>No</b>
25A. COUNTY <b>Skamania</b>		25B. LENGTH OF RES. IN CO. <b>19 yrs</b>	26. STATE <b>Washington</b>
27. ZIP CODE <b>98648</b>		28. FATHER'S NAME—FIRST, MIDDLE, LAST <b>Delbert D Roberts</b>	
29. MOTHER'S NAME—FIRST, MIDDLE, M.A.Z.E.N. SURNAME <b>Charlotte Nellie Downs</b>		30. INFORMANT—NAME <b>Dorothea A Roberts</b>	
31. MAILING ADDRESS—STREET OR RFD NO. CITY OR TOWN STATE ZIP <b>72 Wedrick Stevenson WA 98648</b>		32. BURIAL, CREMATION OR OTHER (Specify) <b>Burial</b>	
33. DATE (Mo, Day, Yr) <b>March 9 1995</b>		34. CEMETERY, CREMATORY, NAME <b>Berge Cemetery</b>	
35. LOCATION—CITY/TOWN, STATE <b>Home Valley WA</b>		36. ADDRESS OF FACILITY—POB 390 <b>WHITE SALMON WA 98672</b>	
37. FUNERAL DIRECTOR SIGNATURE <i>C. M. [Signature]</i>		38. NAME OF FACILITY <b>GARDNER FUNERAL HOME INC.</b>	
39. 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 <i>[Signature]</i> MD		40. 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 <i>[Signature]</i>	
41. DATE SIGNED (Mo, Day, Yr) <b>3-7-95</b>	42. HOUR OF DEATH (24 Hrs) <b>1840</b>	43. DATE SIGNED (Mo, Day, Yr)	44. HOUR OF DEATH (24 Hrs)
45. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) <b>J. Buchanan, MD</b>		46. PRONOUNCED DEAD (Mo, Day, Yr)	
47. HOUR PRONOUNCED DEAD (24 Hrs)		48. MEDICINE FILE NUMBER	
49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) <b>Gary Regalbuto, MD 1410 May St. Hood River, OR 97031</b>			
50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH.			
IMMEDIATE CAUSE (First disease or condition according to death)		INTERVAL BETWEEN ONSET AND DEATH	
A. <b>Chronic Obstructive Pulmonary Disease</b>		1 year	
DO NOT ENTER THE MODE OF DYING, SUCH AS CHOKING OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. Separately 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	
B. _____		INTERVAL BETWEEN ONSET AND DEATH	
C. _____		INTERVAL BETWEEN ONSET AND DEATH	
D. _____		INTERVAL BETWEEN ONSET AND DEATH	
51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE: <b>Congestive Heart Failure</b>			
52. ACC. SUICIDE, HOMICIDE, OR PENDING INVEST. (Specify)	53. INJURY DATE (Mo, Day, Yr)	54. HOUR OF INJURY (24 Hrs)	55. DESCRIBE HOW INJURY OCCURRED
56. INJURY AT WORK? (Yes / No)	57. PLACE OF INJURY—AT HOME, FARM, STREET, YARD, OR OTHER LOCATION—STREET OR RFD NO., CITY/TOWN, STATE		



*[Signature]*  
**GARY R. STEINGART, M. D.**  
District Health Officer

SEAL

COH 01-003 (5/92)

STATE OF WASHINGTON  
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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USE ONLY  
DISTRICT  
COPIES  
HOSPITAL  
OCCUPATION  
RESIDENCE  
TRUCK  
OCCUPATION  
ACC LDC  
OWNER

LOCAL FILE NUMBER

1. NAME: **Wills Dell ROBERTS**

2. SEX (M / F): **Male**

3. DEATH DATE (Mo, Day, Yr): **March 5 1995**

4. AGE LAST BIRTHDAY: **83**

5. UNDER 1 YEAR: **MO**

6. UNDER 1 DAY: **HRS**

7. BIRTH DATE (Mo, Day, Yr): **June 9 1911**

8. BIRTH PLACE: **Gloversville NY**

9. COUNTY OF DEATH: **Klickitat**

10. CITY, TOWN OR LOCATION OF DEATH: **White Salmon**

11. PLACE OF DEATH: **Skyline Hospital**

12. SMOKING IN LAST 15 YEARS? (Yes / No): **No**

13. MARITAL STATUS: **Married**

14. SURVIVING SPOUSE: **Dorothea A Swartwood**

15. SOCIAL SECURITY NO: [REDACTED]

16. DECEDENT'S EDUCATION: **Elementary Secondary (8-12)**

17. USUAL OCCUPATION: **Maintenance/Trimmer**

18. KIND OF BUSINESS OR INDUSTRY: **Sawmill**

19. WAS DECEDENT OF HISPANIC ORIGIN OR DESCENT? (Specify Yes or No): **No**

20. RACE (Specify): **White**

21. RESIDENCE - NUMBER AND STREET: **72 Wedrick**

22. CITY/TOWN OR LOCATION: **Stevenson**

23. INSIDE CITY LIMITS? (Yes / No): **No**

24. COUNTY: **Skamania**

25. LENGTH OF RES. IN CO.: **19 yrs**

26. STATE: **Washington**

27. ZIP CODE: **98648**

28. FATHER'S NAME - FIRST, MIDDLE, LAST: **Delbert D Roberts**

29. MOTHER'S NAME - FIRST, MIDDLE, MARRIAGE SURNAME: **Charlotte Nellie Downs**

30. INFORMANT - NAME: **Dorothea A Roberts**

31. MAILING ADDRESS: **72 Wedrick Stevenson WA 98648**

32. BURIAL CREMATION: **Burial**

33. DATE (Mo, Day, Yr): **March 9 1995**

34. CEMETERY/CREMATORY - NAME: **Berge Cemetery**

35. LOCATION - CITY/TOWN, STATE: **Home Valley WA**

36. FUNERAL DIRECTOR OR BURIAL: **X C. M. Duvich**

37. NAME OF FACILITY: **GARDNER FUNERAL HOME INC.**

38. ADDRESS OF FACILITY: **POB 390 WHITE SALMON WA 98672**

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

40. SIGNATURE AND TITLE: **J. Buchanan MD**

41. DATE SIGNED (Mo, Day, Yr): **3-7-95**

42. HOUR OF DEATH (24 Hrs): **1840**

43. 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.

44. SIGNATURE AND TITLE: [REDACTED]

45. DATE SIGNED (Mo, Day, Yr): [REDACTED]

46. HOUR OF DEATH (24 Hrs): [REDACTED]

47. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print): **J. Buchanan, MD**

48. NAME AND ADDRESS OF CERTIFIER - PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): **Gary Regalbuto, MD 1410 May St. Hood River, OR 97031**

49. HOUR PRONOUNCED DEAD (24 Hrs): [REDACTED]

50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:

IMMEDIATE CAUSE (Final disease or condition resulting in death): **Chronic Obstructive Pulmonary Disease, ypr**

DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. Separately list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.

51. OTHER SIGNIFICANT CONDITIONS - CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE: **Congestive Heart Failure**

52. ACCIDENT, SUICIDE, HOMICIDE, UNDET. OR PENDING INVEST. (Specify): **No**

53. INJURY DATE (Mo, Day, Yr): [REDACTED]

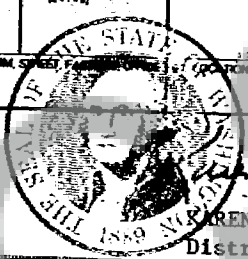
54. HOUR OF INJURY (24 Hrs): [REDACTED]

55. DESCRIBE HOW INJURY OCCURRED: [REDACTED]

56. INJURY AT WORK? (Yes / No): **No**

57. PLACE OF INJURY - AT HOME, FARM, STREET, PARKING GARAGE, BLDG, ETC. (Specify): [REDACTED]

58. STREET OR RFD NO., CITY/TOWN, STATE: [REDACTED]



**Karen R. Steingart, M.D.**  
District Health Officer

MAR 03 1995

**Karen Steingart**  
Dr. Karen Steingart  
Health Officer  
Skamania Health Dist.

BB481703



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH

Health

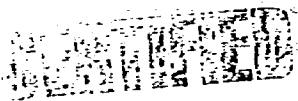
CERTIFICATE OF DEATH

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LOCAL FILE NUMBER		1. NAME Wills Dell ROBERTS		2. SEX (M / F) Male		3. DEATH DATE (Mo, Day, Yr) March 5 1995	
4. AGE LAST BIRTH 37 yrs		5. UNDER 1 YEAR MOS DAYS		6. UNDER 1 DAY HOURS MINS		7. BIRTH DATE (Mo, Day, Yr) June 9 1911	
8. BIRTH PLACE Grovesville NY		9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No)		10. COUNTY OF DEATH Klickitat		11. CITY, TOWN OR LOCATION OF DEATH White Salmon	
12. PLACE OF DEATH - <input type="checkbox"/> HOME <input type="checkbox"/> IN HOSPITAL <input checked="" type="checkbox"/> CARE HOME <input type="checkbox"/> HOSP <input type="checkbox"/> NUR HOME <input type="checkbox"/> OTHER PLACE Skyline Hospital		13. SMOKING IN LAST 15 YEARS? (Yes / No) No		14. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		15. SURVIVING SPOUSE (If wife, give maiden name) Dorothea A Swartwood	
16. SOCIAL SECURITY NO.		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (14 or 16)		18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) Maintenance/Trimmer		19. KIND OF BUSINESS OR INDUSTRY Sawmill	
20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify: NO		21. RACE (Specify) White		22. RESIDENCE - NUMBER AND STREET 72 Wedrick		23. CITY/TOWN OR LOCATION Stevenson	
24. INSIDE CITY LA 1/2 P 143		25A. COUNTY Skamania		25B. LENGTH OF RES. IN CO 19 yrs		26. STATE Washington	
27. ZIP CODE 98648		28. FATHER'S NAME - FIRST, MIDDLE, LAST Delbert D Roberts		29. MOTHER'S NAME - FIRST, MIDDLE, MARRIAGE SURNAME Charlotte Nellie Downs		30. INFORMANT - NAME Dorothea A Roberts	
31. MAILING ADDRESS 72 Wedrick Stevenson WA 98648		32. BURIAL/CREMATION Burial		33. DATE (Mo, Day, Yr) March 9 1995		34. CEMETERY/CREMATORY - NAME Berge Cemetery	
35. LOCATION - CITY/TOWN STATE Home Valley WA		36. FUNERAL DIRECTOR SIGNATURE C. M. Dindiche		37. NAME OF FACILITY GARDNER FUNERAL HOME INC.		38. ADDRESS OF FACILITY POB 390 WHITE SALMON WA 98672	
TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN				TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER			
39. 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 J. Buchanan, MD				40. 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			
41. DATE SIGNED (Mo, Day, Yr) 3-7-95		42. HOUR OF DEATH (24 Hrs) 1840		43. DATE SIGNED (Mo, Day, Yr)		44. HOUR OF DEATH (24 Hrs)	
45. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) J. Buchanan, MD				46. PRONOUNCED DEAD (Mo, Day, Yr)		47. HOUR PRONOUNCED DEAD (24 Hrs)	
48. NAME AND ADDRESS OF CERTIFIER - PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) Gary Regalbuto, MD 1410 May St. Hood River, OR 97031				49. MEDICORNER FILE NUMBER			
50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:							
IMMEDIATE CAUSE (Final illness or condition resulting in death)		A. Chronic Obstructive Pulmonary Disease				INTERVAL BETWEEN ONSET AND DEATH years	
DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Illness or injury which initiated events resulting in death) LAST.		B. DUE TO, OR AS A CONSEQUENCE OF:		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: Congestive Heart Failure		52. AUTOPSY? (Yes / No) No		53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No) No		INTERVAL BETWEEN ONSET AND DEATH	
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 / No)		59. PLACE OF INJURY - AT HOME, FARM, SCHOOL, BLDG, ETC. (Specify)		60. STREET OR RD NO., CITY/TOWN, STATE			



Karen R. Steingart, M.D.  
District Health Officer



MAR 03 1995  
Karen Steingart  
Dr. Karen Steingart  
Health District Officer  
3300 Wash. Health Dist.

BB481703