Record

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

Declaration of Heirship, 124004 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 30th day of November, 1995.

Dorothea Roberts
DOROTHEA A. ROBERTS

STATE OF WASHINGTON)
: ss.
County of Skamania)

SUBSCRIBED and SWORN to before me this 30th day of November, 1995.

JAMES D. JONES NOTARY PUBLIC STATE OF WASHINGTON 2-29-97

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

Recorded ✓
Indexed, Dir ✓
Indirect ✓
Filmed
Mailed

Unofficial Copy

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Health

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

146
BOOK 154 PAGE 151

STATE FILE NUMBER

USE ONLY
1 DISTRICT
2 COPIES 5
3 HOSPITAL
4 OCCURRENCE
5 RESIDENCE
6 TRACT
7 OCCUPATION

1. NAME: Willis (First) Dell (Middle) ROBERTS (Last)
2. SEX (M / F): Male
3. DEATH DATE (Mo, Day, Yr): March 5 1995
4. AGE LAST BIRTHDAY (Yrs): 83
5. UNDER 1 YEAR: MOS / DAYS
6. UNDER 1 DAY: HOURS / MINS
7. BIRTHDATE (Mo, Day, Yr): June 9 1911
8. BIRTHPLACE (City, State or Foreign Country): Gloversville NY
9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No): No
10. COUNTY OF DEATH: Klickitat
11. CITY, TOWN OR LOCATION OF DEATH: White Salmon
12. PLACE OF DEATH - BE BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME: 1 ☐ HOME 2 ☐ IN TRANSPORT 3 X EMERG RM/OUT PTN 4 ☐ HOSP. 5 ☐ NUR HOME 6 ☐ 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: [redacted]
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
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 LIMITS? (Yes / No): NO
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, MAIDEN SURNAME: Charlotte Nellie Downs
30. INFORMANT—NAME: Dorothea A Roberts
31. MAILING ADDRESS (STREET OR RFD NO, CITY OR TOWN, STATE, ZIP): 72 Wedrick Stevenson WA 98648
32. BURIAL, CREMATION, REMOVAL, OTHER (Specify): 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: X C. M. Dissinger
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

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: X [signature] MD
40. DATE SIGNED (Mo, Day, Yr): 3-7-95
41. HOUR OF DEATH (24 Hrs): 1840
42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print): J. Buchanan, MD
43. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): Gary Regalbuto, MD 1410 May St. Hood River, OR 97031

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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
SIGNATURE AND TITLE: X
44. DATE SIGNED (Mo, Day, Yr):
45. HOUR OF DEATH (24 Hrs):
46. PRONOUNCED DEAD (Mo, Day, Yr):
47. HOUR PRONOUNCED DEAD (24 Hrs):
48. MEDICAL EXAMINER OR CORONER FILE NUMBER:

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

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. Chronic Obstructive Pulmonary Disease — INTERVAL BETWEEN ONSET AND DEATH: years
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:
DUE TO, OR AS A CONSEQUENCE OF:
D. — 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
54. ACC. SUICIDE, HOM., 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) LOCATION—STREET OR RFD NO., CITY/TOWN, STATE:

SEAL

Karen Steingart, MD
KAREN R. STEINGART, M. D.
District Health Officer

DOH 01-003 (5/92)

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VOID COPY

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Health

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

146
BOOK 154 PAGE 151

STATE FILE NUMBER

1. NAME (First, Middle, Last)	Willis Dell ROBERTS
2. SEX (M / F)	Male
3. DEATH DATE (Mo. Day. Yr)	March 5 1995
4. AGE LAST BIRTHDAY (Yrs)	83
5. UNDER 1 YEAR (MOS / DAYS)	
6. UNDER 1 DAY (HOURS / MINS)	
7. BIRTHDATE (Mo. Day. Yr)	June 9 1911
8. BIRTHPLACE (City, State or Foreign Country)	Gloversville 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—See Box for Place then Give Address or Institution Name (1 ☐ Home 2 ☐ In Transport 3 X Emerg. Room/Ft 4 ☐ Hosp. 5 ☐ Nur. Home 6 ☐ 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.	[redacted]
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	10
College (1-4 or 5+)	
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 LIMITS? (Yes / No)	NO
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, MAIDEN SURNAME	Charlotte Nellie Downs
30. INFORMANT—NAME	Dorothea A Roberts
31. MAILING ADDRESS (Street or RFD No. / City or Town / State / Zip)	72 Wedrick Stevenson WA 98648
32. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	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	X C. M. Dierdorf
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

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 X [signature] MD

40. DATE SIGNED (Mo., Day, Yr) 3-7-95

41. HOUR OF DEATH (24 Hrs.) 1840

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

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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.

SIGNATURE AND TITLE X

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

45. HOUR OF DEATH (24 Hrs.)

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. ME/CORONER FILE NUMBER

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

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.

		Interval between onset and death
A.	Chronic Obstructive Pulmonary Disease	1 year
	DUE TO, OR AS A CONSEQUENCE OF:	
B.		
	DUE TO, OR AS A CONSEQUENCE OF:	
C.		
	DUE TO, OR AS A CONSEQUENCE OF:	
D.		

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

54. ACC. SUICIDE, HOM., 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) LOCATION—STREET OR RFD NO., CITY/TOWN, STATE

SEAL

Karen Steingart, MD

KAREN R. STEINGART, M. D.
District Health Officer

DOH 01-003 (592)

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Health

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

146
BOOK 154 PAGE 151
STATE FILE NUMBER

USE ONLY

1. DISTRICT
2. COPIES: 5
3. HOSPITAL
4. OCCURRENCE
5. RESIDENCE
6. TRACT
7. OCCUPATION

1. NAME: First Willis Middle Dell Last ROBERTS
2. SEX (M / F): Male
3. DEATH DATE (Mo. Day. Yr.): March 5 1995
4. AGE LAST BIRTHDAY (Yrs): 83
5. UNDER 1 YEAR: MOS. DAYS
6. UNDER 1 DAY: HOURS MINS
7. BIRTHDATE (Mo. Day. Yr.): June 9 1911
8. BIRTHPLACE (City, State or Foreign Country): Gloversville NY
9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No): No
10. COUNTY OF DEATH: Klickitat
11. CITY, TOWN OR LOCATION OF DEATH: White Salmon
12. PLACE OF DEATH: 1 ☐ HOME 2 ☐ IN TRANSPORT 3 X DR'S. IN/OUT PTN. 4 ☐ HOSP. 5 ☐ NUR. HOME 6 ☐ 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.: [redacted]
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
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 LIMITS? (Yes / No): No
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, MAIDEN SURNAME: Charlotte Nellie Downs
30. INFORMANT—NAME: Dorothea A Roberts
31. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP: 72 Wedrick Stevenson WA 98648
32. BURIAL, CREMATION, REMOVAL, OTHER (Specify): 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: X C. M. Dirksen
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

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: X MD
40. DATE SIGNED (Mo., Day, Yr.): 3-7-95
41. HOUR OF DEATH (24 Hrs.): 1840
42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print): J. Buchanan, MD

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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.
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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
48. ME/CORONER FILE NUMBER

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

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. Chronic Obstructive Pulmonary Disease — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF: — INTERVAL BETWEEN ONSET AND DEATH:
B.
DUE TO, OR AS A CONSEQUENCE OF: — INTERVAL BETWEEN ONSET AND DEATH:
C.
DUE TO, OR AS A CONSEQUENCE OF: — INTERVAL BETWEEN ONSET AND DEATH:
D.

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
54. ACC. SUICIDE, HOM., 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

SEAL

THE STATE OF WASHINGTON 1889

Karen Steingart, MD
KAREN R. STEINGART, M. D.
District Health Officer

DOH 61-003 (5/92)

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MAR 0 3 1995

Karen Steingart
Dr. Karen Steingart
Health District Officer
SW Wash. Health Dist.

BB481703

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Health

CERTIFICATE OF DEATH

146
BOOK 154 PAGE 151

USE ONLY
1. DISTRICT
2. CODE 5
3. HOSPITAL
4. OCCURRENCE
5. RESIDENCE
6. FACT
7. OCCUPATION

LOCAL FILE NUMBER

1. NAME: First Dell Middle Last ROBERTS Wills
2. SEX (M / F): Male
3. DEATH DATE (Mo. Day. Yr): March 5 1995
4. AGE LAST BIRTHDAY (Give age): 83
5. UNDER 1 YEAR: MOS DAYS
6. UNDER 1 DAY: HOURS MINS
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10. COUNTY OF DEATH: Klickitat
11. CITY, TOWN OR LOCATION OF DEATH: White Salmon
12. PLACE OF DEATH: ☒ BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1 ☐ HOME 2 ☐ IN TRANSIT 3 X DEAD ON ARRIVAL 4 ☐ HOSP. 5 ☐ NUR HOME 6 ☐ 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
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30. INFORMANT - NAME: Dorothea A Roberts
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43. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print): Gary Regalbuto, MD 1410 May St. Hood River, OR 97031

TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER

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.
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45. HOUR OF DEATH (24 Hrs.):
46. PRONOUNCED DEAD (Mo. Day. Yr):
47. HOUR PRONOUNCED DEAD (24 Hrs.):
48. ME/CORONER FILE NUMBER:

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)
A. Chronic Obstructive Pulmonary Disease. years — INTERVAL BETWEEN ONSET AND DEATH
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
DUE TO, OR AS A CONSEQUENCE OF:
D. — INTERVAL BETWEEN ONSET AND 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. 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. AUTOPSY? (Yes / No): No
53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No): No
54. ACC. SUICIDE, HOM., 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:

SEAL

Karen Steingart, MD
KAREN R. STEINGART, M. D.
District Health Officer

DOH 01-003 (5/92)

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UNOFFICIAL COPY

RECEIVED
MAR 06 1995

Karen Steingart
Dr. Karen Steingart
Health District Officer
SW Wash Health Dist.

BB481703