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SKAMANIA CO. WASH
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OLowry
AUDITOR
GARY M. OLSON

Return Address:
EUGENE E. HOWARD
P.O. BOX 128
WASHOUGAL, WA 98671

First American Title Insurance Company

Sk 20647

Document Title(s) (for transactions contained therein): 1. CERTIFICATE OF DEATH 2. 3. 4.
Reference Number(s) of Documents assigned or released: (on page__of document(s))
Grantor(s) 1. ZOLA M. HOWARD 2. 3. 4. Additional Names on page of document.
Grantee(s) 1. EUGENE E. HOWARD 2. 3. 4. Additional Names on page of document.
Legal Description (abbreviated i.e. lot, block, plat or section, township, range) S1/2 of the NE 1/4 of Sec 8, T1N, R5E Additional legal is on page of document.
Assessor's Property Tax Parcel/Account Number 01-05-08-0-0-0900 and FIRE PATROL
The Auditor/Recorder will rely on information provided on the form. The staff will not read the document to verfiy the accuracy or completeness of the indexing information provided herein.

1-5-8-900
5-5-97

Registered ✓
Indexed, Dir ✓

REAL ESTATE EXCISE TAX
18782
MAY 5 1997
PAID exempt
V. Lowry, Deputy
SKAMANIA COUNTY TREASURER

CERTIFICATION OF VITAL RECORD

C-7668

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

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ID. TAG NO. 02144
Local File Number

State File Number

1. DECEDENT'S NAME: Zola Mae HOWARD
2. SEX: Female
3. DATE OF DEATH (Month, Day, Year): November 26, 1996
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE-Last Birthday (Years): 73
5b. Under 1 Year: Mos. / Days
5c. Under 1 Day: Hours / Mins.
5. BIRTHPLACE (City and State or Foreign Country): Hindman, Kentucky
7. DATE OF BIRTH (Month, Day, Year): February 7, 1923
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No
9a. PLACE OF DEATH (Check only one): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Kaiser Sunnyside Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Clackamas
9d. COUNTY OF DEATH: Clackamas
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
10b. KIND OF BUSINESS/INDUSTRY: Own Home
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married
12. SURVIVING SPOUSE (If Married, Widowed, or Divorced - Give Name Prior Husband or Wife): Eugene Howard
13a. RESIDENCE - STATE: Washington
13b. COUNTY: Clark
13c. CITY, TOWN OR LOCATION: Washougal
13d. STREET AND NUMBER: 1472 Belle Center Road
13e. INSIDE CITY LIMITS? ☐ Yes ☒ No
13f. ZIP CODE: 98671
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify
15. RACE - American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
17. FATHER - NAME first middle last: Isaac Smith
18. MOTHER - NAME first middle maiden: Arnett Taylor
19. INFORMANT - NAME and relationship to Deceased: Eugene Howard - Husband
20a. METHOD OF DISPOSITION: ☐ Mausoleum ☐ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Portland Crematory
20c. LOCATION - City or Town, State: Portland, Oregon
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Ron Brown
21b. LICENSE NUMBER (Of Licensee): 1017
22. NAME, ADDRESS AND ZIP OF FACILITY: 410 NE Garfield St. Brown's Funeral Home Camas, Wa 98607
23. DATE FILED (Month, Day, Year): DEC 5 - 1996
24. REGISTRAR'S SIGNATURE: Mozelle A Thompson
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☐ YES ☐ NO ☒ N/A
26. WAS GIFT MADE? ☐ YES ☐ NO ☐ N/A

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 2320 M
28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes ☒ No
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature): Allen Alexander MD
30. DATE SIGNED (Month, Day, Year): 12-3-96

TO BE COMPLETED ONLY BY MEDICAL EXAMINER

31a. TIME OF DEATH: M
31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour): M
32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated. (Signature)
33. DATE SIGNED (Month, Day, Year)
COUNTY

34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print): Allen Alexander MD 16713 SE McGillivray Blvd Vancouver Wa
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

36. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest
PART I
(a) Scleroderma — Interval between onset and death: 30 yrs
DUE TO, OR AS A CONSEQUENCE OF:
(b)
DUE TO, OR AS A CONSEQUENCE OF:
(c)
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.

37. Did tobacco use contribute to this death? ☐ Yes ☐ Probably ☐ No ☒ Unknown
38. AUTOPSY ☐ Yes ☒ No
39. Were there any findings considered in determining cause of death? ☐ Yes ☐ No ☐ N/A

40. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention
41a. DATE OF INJURY (Month, Day, Year)
41b. TIME OF INJURY
41c. INJURY AT WORK? ☐ Yes ☐ No
41d. DESCRIBE HOW INJURY OCCURRED
41e. PLACE OF INJURY - At home, farm, street, factory, office building etc. (Specify)
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

RESERVED FOR REGISTRAR'S USE

REAL ESTATE EXCISE TAX
18782
MAY 5 1997
PAID
CLACKAMAS COUNTY TREASURER

ORIGINAL-VITAL STATISTICS COPY

THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE CLACKAMAS COUNTY REGISTRAR.

DATE ISSUED: DEC 23 1996

THOMAS M. TROXEL
COUNTY REGISTRAR
CLACKAMAS COUNTY, OREGON

1-5-97

ANY ALTERATION ERASURE VOIDS THIS CERTIFICATE