129702

BOOK 170 PAGE 738

FILED FOR RECORD
SKAMANIA COUNTY WASH
BY Irvin W. Sterns Jr.

NOV 7 11 39 AM '97
O Lavory
AUDITOR
GARY H. OLSON

Return Address:

Irvin W. Sterns, Jr
P.O. Box 422
Stevenson, Wa. 98648

Gary H. Martin, Skamania County Assessor
Date 11/7/97 Parcel # 3-7-36-3-4-6600
2-7-1-1-800

Please Print or Type Information.

Document Title(s) or transactions contained therein:

1. Death Certificate
2.
3.
4.

GRANTOR(S) (Last name, first, then first name and initials)

1. Irvin W. Sterns, Jr. & Catherine A. Sterns H/W
2. P.O. Box 422
3. Stevenson, Wa. 98648
4.

[ ] Additional Names on page _____ of document.

REAL ESTATE EXCISE TAX

19128

NOV -7 1997

PAID Exempt

SKAMANIA COUNTY TREASURER

GRANTEE(S) (Last name, first, then first name and initials)

1. Irvin W. Sterns, Jr.
2. P.O. Box 422
3. Stevenson, Wa. 98648
4.

[ ] Additional Names on page _____ of document.

LEGAL DESCRIPTION (Abbreviated: I.E., Lot, Block, Plat or Section, Township, Range, Quarter/Quarter)

[ ] Complete legal on page _____ of document.

REFERENCE NUMBER(S) Of Documents assigned or released:
Community Property Agreement recorded Vol 48 Page 359

[ ] Additional numbers on page _____ of document.

ASSESSOR'S PROPERTY TAX PARCEL/ACCOUNT NUMBER
3-7-36-3-4-6600 & 2-7-1-1-800
[ ] Property Tax Parcel ID is not yet assigned.
[ ] Additional parcel #'s on page _____ of document.

Requested
Verified
Scanned
Indexed
Mailed

The Auditor/Recorder will rely on the information provided on the form. The Staff will not read the document to verify the accuracy or completeness of the indexing information.

CERTIFICATION OF VITAL RECORD

BOOK 170 PAGE 739

C-0012
I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF DEATH

Local File Number — 136- — State File Number

DECEDENT

1. DECEDENT'S NAME — First: Catherine — Middle: A. — Last: STERNS
2. SEX: Female
3. DATE OF DEATH (Month, Day, Year): March 10,1992
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE - Last Birthday (Years): 68
5b. Under 1 Year: Mos. / Days
5c. Under 1 Day: Hours / Mins.
6. BIRTHPLACE (City and State or Foreign Country): Spokane, WA
7. DATE OF BIRTH (Month, Day, Year): Jan. 13, 1924
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): Good Samaritan Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Portland
9d. COUNTY OF DEATH: Multnomah
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Registered Nurse
10b. KIND OF BUSINESS/INDUSTRY: Nursing
11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify): Married
12. SPOUSE (If Married, Widowed): Irvin W.
13a. RESIDENCE - STATE: Washington
13b. COUNTY: Skamania
13c. CITY, TOWN, OR LOCATION: Stevenson
13d. STREET AND NUMBER: 407 Vancouver Ave.
13e. INSIDE CITY LIMITS? ☒ Yes ☐ No
13f. ZIP CODE: 98648
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): — College (1-4 or 5+): 4

PARENTS

17. FATHER - NAME first middle last: Joseph - Miller
18. MOTHER - NAME first middle maiden: Agnes - O'Leary
19. INFORMANT - NAME and relationship to deceased: Irvin W. Sterns, Husband

DISPOSITION

20a. METHOD OF DISPOSITION: ☐ Mausoleum ☐ Burial ☒ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Park Hill Crematory
20c. LOCATION - City or Town, State: Vancouver, WA

REGISTRAR

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: R. Dwiggins
21b. LICENSE NUMBER (Of Licensee): 1482
22. NAME, ADDRESS AND ZIP OF FACILITY: Box 390 Gardner Funeral Home, Inc White Salmon, WA 98672
23. DATE FILED (Month, Day, Year): MAR 23 1992
24. REGISTRAR'S SIGNATURE: Arthur W. Bloom
25. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? ☒ YES ☐ NO ☐ N/A
26. WAS GIFT MADE? ☐ YES ☒ NO ☐ N/A

CERTIFIER

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH: 1600 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)
30. DATE SIGNED (Month, Day, Year): March 16, 1992.

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): Raymond Petrillo, M.D. 1130 NW 22nd Ave. Suite 640 Portland, OR 97210
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GIVE 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) Acute Respiratory Failure — Interval between onset and death: 1 hour
DUE TO, OR AS A CONSEQUENCE OF:
(b) Acute Renal Failure — Interval between onset and death: 6 wks
DUE TO, OR AS A CONSEQUENCE OF:
(c) Sepsis + Drug toxicity (Amphotericin B) — Interval between onset and death:

PART II
OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I: Alcoholism / Hepatitis C / candida peritonitis

37. Did tobacco use contribute to the death? ☐ Yes ☐ No ☒ Probably ☐ Unk
38. AUTOPSY: ☐ Yes ☒ No
39. If YES were 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: M
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

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

DATE ISSUED: MAR 2 3 1992

Issued — ARTHUR W. BLOOM, COUNTY REGISTRAR
MULTNOMAH COUNTY, OREGON

STATE OF OREGON 1859

MULTNOMAH COUNTY OREGON 1854

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE