

135194

BOOK 189 PAGE 450

FILED IN RECORD
SPRINGFIELD WASH
BY Glen Miller

MAY 18 2 17 PM '93

CLERK
GARY H. OLSON

RETURN ADDRESS:

Glen R. Miller
P. O. Box 252
Underwood, WA 98651

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. Miller, Joanne Louise
- 2.
- 3.
- 4.

Additional Names on page _____ of document.

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

1. The Public
- 2.
- 3.
- 4.

Additional Names on page _____ of document.

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

N/A

Additional Names on page _____ of document.

REFERENCE NUMBER(S) Of Documents assigned or released:

Additional Names on page _____ of document.

ASSESSOR'S PROPERTY TAX PARCEL/ACCOUNT NUMBER

N/A

Property Tax Parcel ID is not yet assigned.

Additional Names on page _____ of document.

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

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TYPE OR PRINT IN PERMANENT BLACK INK

258 481 I.D. TAG NO
4091-98 Local File Number

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

State File Number

1. DECEDENT'S NAME First: Joanne Louise Last: MILLER		2. SEX Female	3. DATE OF DEATH (Month, Day, Year) August 6, 1998
4. SOCIAL SECURITY NUMBER	5a. AGE Last Birthday (Years) 72	5b. Under 1 Year Mo: Days	5c. Under 1 Day Hours: Mins
6. PLACE OF DEATH (Check only one) a. HOME <input type="checkbox"/> b. NURSING HOME <input type="checkbox"/> c. DECEDENT'S HOME <input type="checkbox"/> d. OTHER (Specify)		7. DATE OF BIRTH (Month, Day, Year)	
8. FACILITY NAME (If not institution, give street and number) Hood River Care Center		9. CITY, TOWN, OR LOCATION OF DEATH Hood River	
10. DECEDENT'S USUAL OCCUPATION (One kind of work done during most of working life. Do not use retired) Secretary		11. MARITAL STATUS (Married, Never Married, Widowed, Divorced) (Specify) Married	
12. RESIDENCE - STATE Washington		13. COUNTY Clark	
14. INSIDE CITY (Last 4) 98607		15. ZIP CODE 98607	
16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) No		17. RACE (American Indian, Black, White, etc.) (Specify) White	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)		19. INFORMANT - NAME and relationship to decedent Glen R. Miller - Husband	
20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Autopsy		21. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Oak Hill Cemetery	
22. DATE FILED (Month, Day, Year) August 7, 1998		23. NAME, ADDRESS AND ZIP OF FACILITY Gable & Parkrose Funeral Chapels, Inc 225 NE 80th Ave., Portland, OR 97213	
24. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH William R. Blum		25. OREGON LICENSE NO. (If Licensed) 3535	
26. SIGNATURE OF REGISTERAR Dorothy A. O'Dell		27. TIME OF DEATH 2130	
28. TO BE COMPLETED BY CERTIFYING PHYSICIAN 28a. TIME OF DEATH 2130		28b. WAS MEDICAL EXAMINER NOTIFIED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
29. TO BE COMPLETED BY MEDICAL EXAMINER 29a. TIME OF DEATH 29b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour)		30. 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) Brenda Colfelt MD	
31. DATE SIGNED (Month, Day, Year) August 7, 1998		32. DATE SIGNED (Month, Day, Year)	
33. NAME, TITLE, ADDRESS AND ZIP OF CERTIFYING MEDICAL EXAMINER (Type or Print) Dr. Brenda Colfelt, MD 849 Pacific Avenue, Hood River, OR 97031		34. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	
35. PART I - UNDERLYING CAUSE 35a. CHRONIC obstructive Pulmonary Disease 35b. Tobacco Use		36. PART II - OTHER SIGNIFICANT CONDITIONS Adenocarcinoma of unknown primary	
37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidents <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Other		38. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)	
39. DATE OF INJURY (Month, Day, Year)		40. TIME OF INJURY	
41. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		42. DESCRIBE HOW INJURY OCCURRED	
43. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		44. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

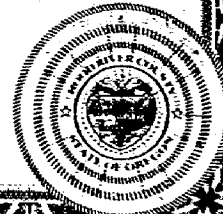
ORIGINAL-VITAL STATISTICS COPY

45-2 Rev 5-98

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

DATE ISSUED: HOOD RIVER AUG 07 1998 COUNTY OREGON

Dorothy A. O'Dell
COUNTY REGISTRAR
HOOD RIVER COUNTY, OREGON



ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE