

140817

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FILED FOR RECORD
SKAMANIA CO. WASH

BY *Kielpinski & Woodrich*
APR 16 10 16 AM '01
G. Lowry
AUDITOR
GARY H. OLSON

After Recording Mail To:
Kielpinski & Woodrich
PO Box 510
Stevenson, WA 98648

AFFIDAVIT IN SUPPORT OF COMMUNITY PROPERTY AGREEMENT

STATE OF WASHINGTON, County of Skamania) ss.

The undersigned, being first duly sworn, on oath deposes and says:

1. This Affidavit provides information for the record regarding that certain Community Property Agreement dated the 9th day of November, 1998 recorded in Skamania County, Washington on April 13, 2001 under Auditor's File No. *140816 Vol 208 Pg 655*. Florence H. Cast (the "Decedent") was one of the parties to the Agreement and died on March 12, 2001, a resident of Skamania County, Washington. A copy of the death certificate is recorded herewith.

2. The parties to the Agreement were legally competent at the time of the Agreement and executed no subsequent Wills or agreements that would have the effect of abrogating or nullifying the Agreement.

3. There was no real property of the parties to the Agreement at the time of the Decedent's death.

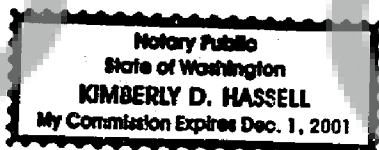
4. The Decedent left no separate property.

5. All the obligations of the marital community owing at the date of the Decedent's death have been paid in full, and all expenses of last illness and for funeral and burial services of the Decedent have been paid in full.

6. The Decedent's husband survives her.

Harold R. Cast
Harold R. Cast

SIGNED AND SWORN to before me this 12th day of April, 2001 by Harold R. Cast.



Kimberly Hassell
Notary Public in and for State of Washington
My commission expires 12/01/01

STATE OF WASHINGTON DEPARTMENT OF HEALTH

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TYPE OR PRINT IN PERMANENT BLACK INK

12

LOCAL FILE NUMBER

CERTIFICATE OF DEATH

146

STATE FILE NUMBER

1. NAME First Middle Last Florence H. Cast				2. SEX (M/F) Female		3. DEATH DATE (Mo., Day, Yr.) March 12, 2001	
4. AGE LAST BIRTH DAY (Yr.) 81		5. UNDER 1 YEAR MOS. DAYS HOURS MINS		7. BIRTH DATE (Mo., Day, Yr.) 11/17/1919		8. BIRTH PLACE (City, State or Foreign Country) Zillah, WA.	
11. CITY, TOWN OR LOCATION OF DEATH Stevenson				12. PLACE OF DEATH — X BOX FOR PLACE IF EN GIVE ADDRESS OR INSTITUTION NAME 1 X HOME 2 () IN TRANSIT 3 () TEMPS. RM OUT RIN 4 () HOSP. 5 () NUR HOME 6 () OTHER PLACE 986 Rock Creek DR. #201		13. COUNTY OF DEATH Skamania	
14. MARITAL STATUS — Married, Never married, Widowed, Divorced (Specify) Married		15. SURVIVING SPOUSE (if wife, give maiden name) Harold Cast		16. SOCIAL SECURITY NO. 538-09-5935		17. DECEASED'S EDUCATION (Specify only, highest grade completed) Elementary Secondary 10-12 12 College (1-4 or 5+) 12	
18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) Sales Clerk		19. KIND OF BUSINESS OR INDUSTRY Clothing		20. Was Decedent of Hispanic, origin or descent? (Specify) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) NO		21. RACE (Specify) White	
22. RESIDENCE — NUMBER AND STREET 986 Rock Creek DR. #201		23. CITY, TOWN OR LOCATION Stevenson		24. INSIDE CITY LIMITS? (Yes/No) Yes		25A. COUNTY Skamania	
				25B. LENGTH OF RES. IN CO. 2 Yrs		26. STATE WA	
						27. ZIP CODE 98648	
28. FATHER'S NAME — FIRST, MIDDLE, LAST Lawrence S. Higgins				29. MOTHER'S NAME — FIRST, MIDDLE, MARRIAGE SURNAME Lillian Frakes			
30. INFORMANT — NAME Larry Cast				31. MAILING ADDRESS — STREET OR RFD NO. CITY OR TOWN STATE ZIP P.O. Box 6 Stevenson, Washington 98648			
32. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Cremation		33. DATE (Mo., Day, Yr.) 03-22-2001		34. CEMETERY, CREMATORY — NAME Portland Memorial Crematory		35. LOCATION — CITY, TOWN, STATE Portland, Oregon	
36. FUNERAL DIRECTOR SIGNATURE x Michael S. Hammond		37. NAME OF FACILITY Davies Cremation & Burial Serv.		38. ADDRESS OF FACILITY P.O. Box 61747 Vancouver, WA., 98666-1747			
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 03/20/01 0545 Hrs				43. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X			
40. DATE SIGNED (Mo., Day, Yr.) 03/20/01				41. HOUR OF DEATH (24 Hrs) 0545 Hrs		44. DATE SIGNED (Mo., Day, Yr.)	
42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) Greg Zuck MD 875 S.W. Rock Creek Dr. Stevenson, WA. 98610				45. PROLONGED DEAD (Mo., Day, Yr.)		47. PROLONGED DEAD (24 Hrs)	
48. NAME AND ADDRESS OF CERTIFIER — PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) Greg Zuck MD 875 S.W. Rock Creek Dr. Stevenson, WA. 98610				49. MEDICORNER 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 CHOKING 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 DUE TO, OR AS A CONSEQUENCE OF				INTERVAL BETWEEN ONSET AND DEATH many yrs	
		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. 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							
54. ACC. SUICIDE, HOMICIDE, 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, IN WORK OFFICE, BLDG. ETC. (Specify)		60. LOCATION — STREET OR RFD NO., CITY, TOWN, STATE			
61. RECORD AMENDMENT (Registrar use only) ITEM DOCUMENTARY EVIDENCE REVIEWED BY DATE				62. REGISTRAR SIGNATURE x [Signature]		63. DATE RECEIVED (Mo., Day, Yr.) MAR 22 2001	

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