

**WHEN RECORDED RETURN TO:**

Ken & Rosalie Henderson  
41 N.W. Dam Rd  
Underwood WA 98651

**DOCUMENT TITLE(S)**

Death Certificate

**REFERENCE NUMBER(S)** of Documents assigned or released:

☐ Additional numbers on page \_\_\_\_ of document.

**GRANTOR(S):**

Irene Dorothy Haworth

☐ Additional names on page \_\_\_\_ of document.

**GRANTEE(S):**

Ken and Rosalie Henderson

☐ Additional names on page \_\_\_\_ of document.

**LEGAL DESCRIPTION** (Abbreviated: i.e. Lot, Block, Plat or Section, Township, Range, Quarter):

☐ Complete legal on page \_\_\_\_ of document.

**TAX PARCEL NUMBER(S):**

☐ Additional parcel numbers on page \_\_\_\_ of document.

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

## CERTIFICATION OF VITAL RECORD

TYPE OR  
PRINT IN  
PERMANENT  
BLACK INK.

500421  
ID TAG NO

OREGON DEPARTMENT OF HUMAN SERVICES  
CENTER FOR HEALTH STATISTICS  
CERTIFICATE OF DEATH

136-

STATE FILE NUMBER

1. Legal Name (Include AKA's if any) Irene Dorothy HAWORTH						2. Death Date (month, day, year) January 16, 2008	
3. Sex (MF) Female		4a. Age - Last Birthday 77		4b. Under 1 Year Days		5. Social Security Number [REDACTED]	
7. Birthdate (month, day, year) June 7, 1930		8a. Birthplace (city/town or County) New York		9b. State or Foreign Country New York		9. Decedent's Education High School Graduate	
10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.) No				11. Decedent's Race(s) White		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
13. Residence: Number and Street (e.g., 123 SE 4th Street, Apt. 101) 3319 West 10th Street				14. City/Town The Dalles		15. State or Foreign Country Oregon	
16. Residence County Wasco				17. Zip Code + 4 97058		18. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. Marital Status at Time of Death Widowed				20. Spouse's Name (if married or widowed, give name prior to full marriage) Lester Haworth			
21. Usual Occupation (indicate type of work done during period of death; DO NOT USE RETIRED) Financial Technician				22. Kind of Business/Industry (DO NOT USE COMPANY NAME) Accounting			
23. Father's Name (First, Middle, Last, Suffix) William Rowe				24. Mother's Name (First, Middle, Last) Ruth Terry			
25. Informant's Name Dennis Campbell		26. Telephone Number (775) 303-1992		27. Relation to Decedent SON		28. Mailing Address (Number & Street, City/Town, State, Zip + 4) PO BOX 1221, Reno, Nevada 89504	
29. Place of Death Nursing Home				30. Facility Name Hood River Care Center			
31. Location of Death (city address) 729 Henderson Road				32. City/Town or Location of Death Hood River		33. State Oregon	
34. Zip Code + 4 97031				35. Method of Disposition Cremation			
36. Place of Disposition (Name of cemetery, crematory, or other place) Columbia River Crematory				37. Location White Salmon, Washington			
38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4) Anderson's Tribute Center (Funerals • Receptions • Cremations) 1401 Belmont Ave., Hood River, Oregon 97031							
39. Date of Disposition (month, day, year) [REDACTED]				40. Funeral Director's Signature [Signature]		41. OR License Number 3807	
42. Registrar's Signature [Signature]				43. Date Received (month, day, year) JAN 22 2008		44. Local File Number 007-2008	
45. Record Amendment				46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
47. Autopsy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				48. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
49. Time of Death 0640							
50. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT ENTER TERMINAL EVENTS such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Final disease or condition resulting in death: <u>Gastrointestinal Bleeding</u> Approximate Interval Onset to Death: <u>Unknown Cause</u> Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE (last disease or injury that initiated the events resulting in death). Due to (or as a consequence of) <u>Unknown Cause</u> Due to (or as a consequence of) <u>Unknown Cause</u> Due to (or as a consequence of) <u>Unknown Cause</u>							
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above: <u>Chronic Kidney Disease, Arteriosclerotic Heart Disease, Diabetes Mellitus II</u>							
52. Manner of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending				53. If Female: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death			
54. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown				55. Date of Injury (month, day, year) [REDACTED]			
56. Time of Injury [REDACTED]				57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area) [REDACTED]			
58. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				59. Location of Injury (Number & Street, City/Town, State, Zip + 4) [REDACTED]			
60. Describe how injury occurred. [REDACTED]							
61. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) [REDACTED]							
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4) Gary Regalbuto, MD, 1410 May Street, Hood River, Oregon 97031 (541) 386-6222							
63. Name and Title of Attending Physician [If Other than Certifier] [REDACTED]							
64. Title of Certifier MD				65. License Number [REDACTED]		66. Date Certified (month, day, year) 01-22-2008	
67. Medical Certifier: To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. [Signature]				68. Medical Examiner: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. [Signature]			
69. Record Amendment							

ORIGINAL - VITAL RECORDS COPY

45-2 (01/06)

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

DATE ISSUED:

JAN 24 2008

THIS COPY IS NOT VALID WITHOUT INTAGLIO STATE SEAL AND BORDER.

Maria C. Santoyo  
MARIA C. SANTOYO  
COUNTY REGISTRAR  
HOOD RIVER COUNTY, OREGON

