

AFTER RECORDING MAIL TO:

Name Harold Wyninger

Address _____

City / State _____

SC 27802

Document Title(s): (or transactions contained therein)

1. DEath Cert
- 2.
- 3.
- 4.

Reference Number(s) of Documents assigned or released:

☐ Additional numbers on page _____ of document

Grantor(s): (Last name first, then first name and initials)

1. Wyninger, Frances Mae
- 2.
- 3.
- 4.
5. ☐ Additional names on page _____ of document

Grantee(s): (Last name first, then first name and initials)

1. Wyninger, Harold JR.
- 2.
- 3.
- 4.
5. ☐ Additional names on page _____ of document

Abbreviated Legal Description as follows: (i.e. lot/block/plat or section/township/range/quarter/quarter)

Lot 11, Block 1 of Woodard Marina Estates, property described in Auditors
File NO. 60610, Pages 114 and 115 of Book A Plats and Records of Skamania
County, State of Washington.

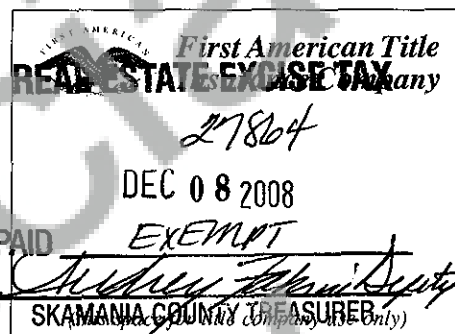
Together with shorelands of the second class as conveyed by the state of
Washington fronting and abutting upon the above described property.

☐ Complete legal description is on page _____ of document

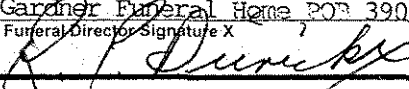

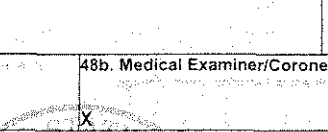
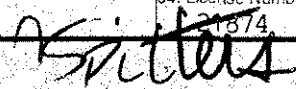
Assessor's Property Tax Parcel / Account Number(s): 02-06-35-2-3-1100-00

WA-1

NOTE: The auditor/recorder will rely on the information on the form. The staff will not read the document to verify the accuracy or completeness of the indexing information provided herein.



STATE OF WASHINGTON DEPARTMENT OF HEALTH

Local File Number 2008-1007		Washington State Certificate of Death		State File Number	
1. Legal Name (include AKA's if any) First Middle LAST Suffix Frances Mae WYNINGER			2. Death Date Jan. 14, 2008		
3. Sex (M/F) Female	4a. Age - Last Birthday 80	4b. Under 1 Year Months Days 0 0	4c. Under 1 Day Hours Minutes 0 0	5. Social Security Number [REDACTED]	6. County of Death Klickitat
7. Birthdate May 2, 1927	8a. Birthplace (City, Town, or County) Hogiam	8b. (State or Foreign Country) Washington	9. Decedent's Education Associate's Degree - Nursing		
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? No	
13a. Residence: Number and Street (e.g., 624 SE 5 th St.) (Include Apt. No.) 692 Skamania Landing Road				13b. City or Town Skamania	
13c. Residence: County Skamania	13d. Tribal Reservation Name (if applicable)	13e. State or Foreign Country Washington	13f. Zip Code + 4 98648	13g. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk	
14. Estimated length of time at residence. 39 Years	15. Marital Status at Time of Death Married	16. Surviving Spouse's Name (Give name prior to first marriage) Harold Wyninger			
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED)) Nurse			18. Kind of Business/Industry (Do not use Company Name) Nursing		
19. Father's Name (First, Middle, Last, Suffix) Frank Krache			20. Mother's Name Before First Marriage (First, Middle, Last) Clara		
21. Informant's Name Karen Wyninger	22. Relationship to Decedent Daughter-in-law	23. Mailing Address: Number and Street or RFD No. City or Town State Zip P.O. Box 346 Carson, WA 98610			
24. Place of Death, if Death Occurred in a Hospital: Inpatient			Place of Death, if Death Occurred Somewhere Other than a Hospital:		
25. Facility Name (if not a facility, give number & street or location) Skyline Hospital			26a. City, Town, or Location of Death White Salmon	26b. State WA	27. Zip Code 98672
28. Method of Disposition Cremation	29. Place of Final Disposition (Name of cemetery, crematory, other place) Columbia River Crematory		30. Location-City/Town, and State White Salmon, Washington		
31. Name and Complete Address of Funeral Facility Gardner Funeral Home POB 390 White Salmon, WA 98672				32. Date of Disposition Jan. 16, 2008	
33. Funeral Director Signature X 					
Cause of Death (See instructions and examples)					
34. 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. Add additional lines if necessary.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Respiratory Failure	Interval between Onset & Death 24 hrs		
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST		b. Sarcoidosis	Due to (or as a consequence of):		Interval between Onset & Death 48 hrs
		c. Guillain-Barre Syndrome	Due to (or as a consequence of):		Interval between Onset & Death 32 yrs
		d.	Due to (or as a consequence of):		Interval between Onset & Death
35. Other significant conditions contributing to death but not resulting in the underlying cause given above			36. Autopsy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	37. Were autopsy findings available to complete the Cause of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		39. If female <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	40. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
41. Date of Injury (MM/DD/YYYY)	42. Hour of Injury (24hrs)	43. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)		44. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
45. Location of Injury: Number & Street: City or Town: _____ County: _____ State: _____ Zip Code + 4: _____			46. Describe how injury occurred		
47. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)					
48a. Certifying Physician X 			48b. Medical Examiner/Coroner X 		
49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print) Greg Zuck POB 1519 White Salmon, WA 98672			50. Hour of Death (24hrs) 1725		
51. Name and Title of Attending Physician if other than Certifier (Type or Print)			52. Date Signed (MM/DD/YYYY) Jan. 15, 2008		
53. Title of Certifier MD	54. License Number 23674	55. ME/Coroner File Number		56. Was case referred to ME/Coroner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
57. Registrar Signature X 			58. Date Received (MM/DD/YYYY) JAN 15 2008		
59. Amendments					