AFN #2009172931 Recorded 05/21/09 at 04:04 PM DocType: DEATH Filed by: Debra A. Tennison Page: 1 of 3 Auditor J. Michael Garvison Skamania County, WA

WHEN RECORDED RETURN TO:

Debra A Tennison
PO Box 11
North Bonneville, WA 98639

DOCUMENT TITLE(S)

death certificate

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

book 81 page 973 AF 95382

[ ] Additional numbers on page _____ of document.

GRANTOR(S):

Jerry D Tennison

[ ] Additional names on page _____ of document.

GRANTEE(S):

Debra A Tennison

[ ] Additional names on page _____ of document.

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

LOT 9 BLK 8 - Relocated North Bonneville B/16 & B/32

[ ] Complete legal on page _____ of document.

TAX PARCEL NUMBER(S):

02072034090 00 Also

[ ] 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.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Local File Number D2 45 **Washington State Certificate of Death** State File Number

Part 1 completed by Funeral Director

1. Legal Name (Include AKA's if any): First: Jerry | Middle: D. | LAST: Tennison | Suffix: | 2. Death Date: 12-23-2008

3. Sex (M/F): M | 4a. Age – Last Birthday: 57 | 4b. Under 1 Year: Months / Days | 4c. Under 1 Day: Hours / Minutes | 5. Social Security Number: [redacted] | 6. County of Death: Skamania

7. Birthdate: 03-27-1951 | 8a. Birthplace (City, Town, or County): Toppenish | 8b. (State or Foreign Country): WA | 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? Yes

13a. Residence: Number and Street (e.g., 624 SE 5th St.) (Include Apt. No.): 809 Celilo | 13b. City or Town: North Bonneville

13c. Residence: County: Skamania | 13d. Tribal Reservation Name (if applicable) | 13e. State or Foreign Country: WA | 13f. Zip Code + 4: 98639 | 13g. Inside City Limits? ☒ Yes ☐ No ☐ Unk

14. Estimated length of time at residence: 29 Years | 15. Marital Status at Time of Death: Married | 16. Surviving Spouse's Name (Give name prior to first marriage): Debra A. Rhode

17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED): Laborer | 18. Kind of Business/Industry (Do not use Company Name): Construction

19. Father's Name (First, Middle, Last, Suffix): Met R. Tennison | 20. Mother's Name Before First Marriage (First, Middle, Last): Helen C. Patterson

21. Informant's Name: Debra Tennison | 22. Relationship to Decedent: Spouse | 23. Mailing Address: Number and Street or RFD No. / City or Town / State / Zip: PO Box 11, North Bonneville, WA 98639

24. Place of Death, if Death Occurred in a Hospital: | Place of Death, if Death Occurred Somewhere Other than a Hospital: Decedent's Residence - Hospice

25. Facility Name (If not a facility, give number & street or location): 809 Celilo | 26a. City, Town, or Location of Death: North Bonneville | 26b. State: WA | 27. Zip Code: 98639

28. Method of Disposition: Cremation | 29. Place of Final Disposition (Name of cemetery, crematory, other place): Cascade Cremation Center | 30. Location-City/Town, and State: Tualatin, OR

31. Name and Complete Address of Funeral Facility: Autumn Funerals & Cremations, 12639 SW Winterview Drive, Tigard, OR 97224 | 32. Date of Disposition: 01-08-2009

33. Funeral Director Signature X: Richard C Hammond

Part 2 completed by Certifier

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.

		Interval between Onset & Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septic Shock	2 days
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	Due to (or as a consequence of): b. Neutropenia	2 weeks
	Due to (or as a consequence of): c. Hemolytic Anemia - Autoimmune	> 6 months
	Due to (or as a consequence of): d. Idiopathic Thrombocytopenic Purpura	> 1 year

35. Other significant conditions contributing to death but not resulting in the underlying cause given above: Transverse myelitis | 36. Autopsy? ☐ Yes ☒ No | 37. Were autopsy findings available to complete the Cause of Death? ☐ Yes ☒ No

38. Manner of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Undetermined ☐ Suicide ☐ Pending

39. If female: ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days before death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year

40. Did tobacco use contribute to death? ☐ Yes ☐ Probably ☒ No ☐ 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? ☐ Yes ☐ No ☐ Unk

45. Location of Injury: Number & Street: | Apt No. | City or Town: | County: | State: | Zip Code+ 4:

46. Describe how injury occurred | 47. If transportation injury, specify: ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (Specify)

48a. Certifying Physician - To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) and manner stated. X Maile Beth Anslinger MD

48b. Medical Examiner/Coroner - 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. X

49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print): Maile Beth Anslinger, MD 1810 E. 19th Street, Ste. 210, The Dalles, Oregon 97058 | 50. Hour of Death (24hrs): 2330

51. Name and Title of Attending Physician if other than Certifier (Type or Print) | 52. Date Signed (MM/DD/YYYY): 01/05/2009

53. Title of Certifier: Medical Doctor | 54. License Number: MD 27642 | 55. ME/Coroner File Number | 56. Was case referred to ME/Coroner? ☒ Yes ☐ No

57. Registrar Signature X | 58. Date Received (MM/DD/YYYY): 01/12/2009

59. Amendments

DOH/CHS 003 Rev 2/06 (OH 01-003 (5/99)

Washington State
Department of Revenue
Special Programs Division
PO Box 47477
Olympia, WA 98504-7477

-Sample Format-

Affidavit of Surviving Spouse or Domestic Partner for Claiming an Exemption Based on Inheritance of Real Estate

State of Washington

County of Skamania

Name of deceased Jerry S Tennison

I, (survivor's name) Debra A Tennison affirm that I am the sole and rightful heir to the property described as:

Parcel number(s) 02072034090000

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed this 21 day of MAY (month), 2009 (year) at Stevenson (city), WA (state)

Debra A Tennison
(Signature of surviving spouse or registered domestic partner)

Debra A Tennison
(Printed name of surviving spouse or registered domestic partner)

PO Box 11 *(Address of surviving spouse or domestic partner)*
~~Stevenson~~ North Bonneville (City) WA (State) 98639 (Zip) & J

Note: *See Senate Bill (SB) 6851 on page 2 for statutory requirements.*