AFTER RECORDING MAIL TO:

Name David & Glenda West

Address PO Box 796

City / State Carson, WA 98610

SCTC 31745

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

1. CERTIFICATE OF DEATH
2.
3.
4.

First American Title Insurance Company

REAL ESTATE EXCISE TAX

28253

APR 29 2010

PAID Exempt

cy deputy

SKAMANIA COUNTY TREASURER

(this space for title company use only)

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. WEST, FLORENCE LUELLA
2.
3.
4.
5. ☐ Additional names on page _____ of document

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

1. WEST, DAVID L.
2. WEST, GLENDA L.
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 1, Block 2, EVERGREEN ACRES, according to the plat thereof, recorded in Book 'A' of Plats, Page 142, in the County of Skamania, State of Washington.

Skamania County Assessor
Date 4-29-10 Parcel# 3-8-21-2-3800

☐ Complete legal description is on page _____ of document

Assessor's Property Tax Parcel / Account Number(s): 03-08-21-2-0-3800-00

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.*

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Local File Number | **Washington State Certificate of Death** | State File Number

1. Legal Name (Include AKA's if any) First: Florence Middle: Luella LAST: WEST Suffix:
2. Death Date: Aug. 4, 2009
3. Sex (M/F): Female
4a. Age – Last Birthday: 85
4b. Under 1 Year: Months Days
4c. Under 1 Day: Hours Minutes
5. Social Security Number: [redacted]
6. County of Death: Skamania
7. Birthdate: Jan. 22, 1924
8a. Birthplace (City, Town, or County): Yreka
8b. (State or Foreign Country): California
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? No
13a. Residence: Number and Street (e.g., 624 SE 5th St.) (Include Apt. No.): 12 Dogwood
13b. City or Town: Carson
13c. Residence: County: Carson
13d. Tribal Reservation Name (if applicable):
13e. State or Foreign Country: Washington
13f. Zip Code + 4: 98610
13g. Inside City Limits? ☐ Yes ☒ No ☐ Unk
14. Estimated length of time at residence: 20 Years
15. Marital Status at Time of Death: Widowed
16. Surviving Spouse's or Domestic Partner's Name (Give name prior to first marriage):
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED): Homemaker
18. Kind of Business/Industry (Do not use Company Name): Own Home
19. Father's Name (First, Middle, Last, Suffix): Charles Arthur Baldwin
20. Mother's Name Before First Marriage (First, Middle, Last): Clara Moser Haug
21. Informant's Name: Dave West
22. Relationship to Decedent: Son
23. Mailing Address: Number and Street or RFD No. PO Box 796 City or Town Carson State WA Zip 98610
24. Place of Death, If Death Occurred in a Hospital:
Place of Death, If Death Occurred Somewhere Other than a Hospital: Decedent's Residence
25. Facility Name (If not a facility, give number & street or location): 12 Dogwood
26a. City, Town, or Location of Death: Carson
26b. State: WA
27. Zip Code: 98610
28. Method of Disposition: Burial/Removal From State
29. Place of Final Disposition (Name of cemetery, crematory, other place): Willamette National Cemetery
30. Location-City/Town, and State: Portland, Oregon
31. Name and Complete Address of Funeral Facility: Gardner Funeral Home PO Box 390 White Salmon, WA 98672
32. Date of Disposition: Aug. 11, 2009
33. Funeral Director Signature X: [signature]

Part 1 completed by Funeral Director

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 arrest R/T Brain tumor — Interval between Onset & Death: ~2 mont

Due to (or as a consequence of):

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. cardiac arrest R/T severe aortic stenosis — Interval between Onset & Death: ~6 months

Due to (or as a consequence of):

c. — Interval between Onset & Death:

Due to (or as a consequence of):

d. — Interval between Onset & Death:

35. Other significant conditions contributing to death but not resulting in the underlying cause given above
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 [signature]
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): Deana Dahl PO Box 390 Stevenson, WA 98648
50. Hour of Death (24hrs): 2310
51. Name and Title of Attending Physician if other than Certifier (Type or Print):
52. Date Signed (MM/DD/YYYY): 8/7/09
53. Title of Certifier: APRN
54. License Number: WA AP 30005544
55. ME/Coroner File Number
56. Was case referred to ME/Coroner? ☒ Yes ☐ No
57. **Registrar Signature** X [signature]
58. Date Received (MM/DD/YYYY): AUG 11 2009
59. Amendments

THE SEAL OF THE STATE OF WASHINGTON 1889

DOH/CHS 003 Rev 07/05/07 DOH 01-003 (6/99)

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