

Return Address:  
Law Office of Anthony H. Connors  
Post Office Box 1116  
White Salmon, WA 98672

<i>Document Title(s) or transactions contained herein:</i>
<b>DEATH CERTIFICATE</b>
<i>GRANTOR(S) (Last name, first name, middle initial)</i>
<b>KOCK, JOHN HANS</b>
<input type="checkbox"/> Additional names on page _____ of document.
<i>GRANTEE(S) (Last name, first name, middle initial)</i>
<b>THE PUBLIC</b>
<input type="checkbox"/> Additional names on page _____ of document.
<i>LEGAL DESCRIPTION (Abbreviated: i.e., Lot, Block, Plat or Section, Township, Range, Quarter/Quarter)</i>
<b>W ½ W ½ NW ¼ SE ¼ OF SEC 26, T 4 N, R 9 E, WM.; and a tract contiguous to and W of SW corner of said tract</b>
<input type="checkbox"/> Complete legal on page _____ of document.
<i>REFERENCE NUMBER(S) of Documents assigned or released:</i>
<b>AF #2006160442</b>
<input type="checkbox"/> Additional numbers on page _____ of document.
<i>ASSESSOR'S PROPERTY TAX PARCEL/ACCOUNT NUMBER</i>
<b>04-09-26-00-05-00</b>
<input type="checkbox"/> Property Tax Parcel ID is not yet assigned
<input type="checkbox"/> Additional parcel numbers on page _____ of document.
The Auditor/Recorder will rely on the information provided on the form. The Staff will not read the document to verify the accuracy or completeness of the indexing information.

# STATE OF OREGON

## CERTIFICATION OF VITAL RECORD


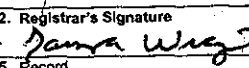
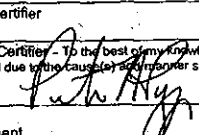
TYPE OR  
PRINT IN  
PERMANENT  
BLACK INK.

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

136-

565499  
I.D. TAG NO.

STATE FILE NUMBER

1. Legal Name (Include AKA's, if any) First: John Middle: Hans Last: KOCK Suffix:			2. Death Date (MON DD YYYY) March 1, 2010		
3. Sex (MF) Male	4a. Age - Last Birthday 83	4b. Under 1 Year Months: Days:	4c. Under 1 Day Hours: Minutes:	5. Social Security Number	6. County of Death Wasco
7. Birthdate (MON DD YYYY) Oct. 26, 1926		8a. Birthplace (City/Town, or County) Hood River		8b. (State or Foreign Country) Oregon	9. Decedent's Education 9-12 Grade, No Diploma
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8) 700 Veterans Drive Wasco			14. City/Town The Dalles		15. Residence County Oregon
16. State or Foreign Country Oregon		17. Zip Code + 4 97058		18. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. Marital Status at Time of Death Married			20. Spouse's Name (If married or widowed, give name prior to first marriage) Estella T. Voigt		
21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.") Truck Driver			22. Kind of Business/Industry (DO NOT USE COMPANY NAME) County Road Department		
23. Father's Name (First, Middle, Last, Suffix) John Fred Kock			24. Mother's Name Prior to First Marriage (First, Middle, Last) Martha M. Walther		
25. Informant's Name Greg Kock		26. Telephone Number 509/538-2604		27. Relation to Decedent Son	
28. Mailing Address (Number & Street, City/Town, State, Zip + 4) 3301 Cook Underwood Rd. Cook, WA 98605					
29. Place of Death Nursing Home		30. Facility Name Oregon Veterans Home			
31. Location of Death (give address) 700 Veterans Drive		32. City/Town or Location of Death The Dalles		33. State OR	34. Zip Code + 4 97058
35. Method of Disposition Removal From State		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) Gardner Funeral Home 1270 N. Main Ave/PO Box 390 White Salmon, WA 98672					
39. Date of Disposition (MON DD YYYY) March 3, 2010		40. Funeral Director's Signature 		41. OR License Number RR64	
42. Registrar's Signature 		43. Date Received (MON DD YYYY) March 30, 2010		44. Local File Number 073	
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 1426					
CAUSE OF DEATH (See instructions and examples.)					
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.					Approximate Interval: Onset to Death
Final disease or condition resulting in death: IMMEDIATE CAUSE a. Dementia					
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).					
b. Due to (or as a consequence of) ↓					
c. Due to (or as a consequence of) ↓					
d. Due to (or as a consequence of) ↓					
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above: Familial Spinal Paralysis, Hypertension, BPH					
52. 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		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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
55. Date of Injury (MON DD YYYY)		56. Time of Injury		57. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)	
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)					
60. Describe how injury occurred.				61. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)	
62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4) Peter Peruzzo 700 Veterans Drive The Dalles, OR 97058					
63. Name and Title of Attending Physician if Other than Certifier					
64. Title of Certifier MD		65. License Number OR 08964		66. Date Signed (MON DD YYYY) 03/23/2010	
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. 			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.		
69. Record Amendment					

ORIGINAL - VITAL RECORDS COPY

45-2 (06/06)

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

DATE ISSUED:

MAR 30 2010

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

  
KATHI HALL  
COUNTY REGISTRAR  
WASCO COUNTY, OREGON