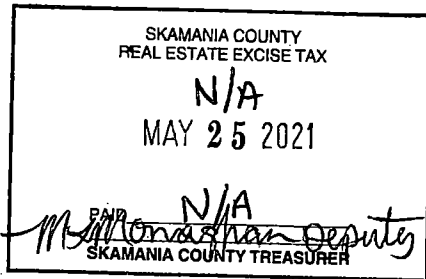


Skamania County, WA
Total: \$105.50
ALP
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2021-001836

05/25/2021 12:24 PM

Request of: ROBERTO FLORES



**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 Juanita A. Flores

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

Parcel number(s) 02062800190000 jm 5/25/21

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 25 day of May, 2021 at Stevenson, WA
(month) (year) (city) (state)

Roberto Flores

(Signature of surviving spouse or registered domestic partner)

Roberto Flores

(Printed name of surviving spouse or registered domestic partner)

5604 N Detroit Portland OR 97217
(Address of surviving spouse or domestic partner) (city) (state) (zip)

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

CERTIFICATION OF VITAL RECORD

TYPE OR
PRINT IN
PERMANENT
BLACK INK.
⑤

451133

I.D. TAG NO.

005422

Local File Number

OREGON DEPARTMENT OF HUMAN SERVICES CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

136-

State File Number

DECEDENT

1.

2.

3.

4.

5.

6.

PARENTS

DISPOSITION

7.

8.

9.

REGISTRAR

10.

11.

CERTIFIER

12.

13.

14.

DESIGNATE
CONDITIONS,
IF ANY,
WHICH GAVE
RISE TO
IMMEDIATE
CAUSE,
STATING THE
UNDERLYING
CAUSE LAST.

CAUSE OF
DEATH

15.

16.

CAUSE OF
DEATH
INSTRUCTIONS
ARE
ON REVERSE
SIDE OF
GREEN
AND
PINK COPY.

1. DECEDENT'S NAME First: Juanita Middle: Arlene Last: FLORES			2. SEX Female		3. DATE OF DEATH (Month, Day, Year) October 24, 2005		
4. SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE-Last Birthday (Years) 64		5b. Under 1 Year Mos. Days Hours Mins.		6. BIRTHPLACE (City and State or Foreign Country) Hammond, Oregon	
7. DATE OF BIRTH (Month, Day, Year) September 22, 1941		8. PLACE OF DEATH (Check one only) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)					
9b. FACILITY NAME (If not an institution, give street and number.) Emanuel Hospital		9c. CITY, TOWN, OR LOCATION OF DEATH Portland		9d. COUNTY OF DEATH Multnomah			
10a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker		10b. KIND OF BUSINESS/INDUSTRY Own Home		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced. (Specify) Married		12. SPOUSE (If Married, Widowed) Roberto	
13a. RESIDENCE - STATE Oregon		13b. COUNTY Multnomah		13c. CITY, TOWN OR LOCATION Portland		13d. STREET AND NUMBER 5604 N Detroit Ave.	
13e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13f. ZIP CODE 97217		14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes) If yes, specify Cuban, Mexican, Puerto Rican, etc. <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		15. RACE American Indian, Black, White, etc. (Specify) White	
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 15+)							
17. FATHER'S NAME First Middle Last Jess Albert Holtzclaw		18. MOTHER'S NAME First Middle Maiden Laura Isabell Church		19. INFORMANT'S NAME and relationship to decedent Roberto Flores, husband			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Mausoleum <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Mount Calvary Cemetery		20c. LOCATION (City or Town, State) Portland, Oregon			
21a. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>John A. Hustad</i>		21b. OREGON LICENSE NO. (Of Licensee) 0262		22. NAME, ADDRESS AND ZIP CODE OF FACILITY Hustad Funeral Home 7232 N Richmond Ave. Portland OR 97203			
23. DATE FILED (Month, Day, Year) NOV 07 2005		24. REGISTRAR'S SIGNATURE <i>Sander L. Reuser</i>					

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10.

11.

CERTIFIER

12.

13.

14.

DESIGNATE
CONDITIONS,
IF ANY,
WHICH GAVE
RISE TO
IMMEDIATE
CAUSE,
STATING THE
UNDERLYING
CAUSE LAST.

CAUSE OF
DEATH

15.

16.

CAUSE OF
DEATH
INSTRUCTIONS
ARE
ON REVERSE
SIDE OF
GREEN
AND
PINK COPY.

TO BE COMPLETED BY MEDICAL CERTIFIER				TO BE COMPLETED ONLY BY MEDICAL EXAMINER			
27. TIME OF DEATH 1150		28. WAS MEDICAL EXAMINER NOTIFIED? (The Medical Examiner MUST be notified of all injury and poisoning deaths.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		31a. TIME OF DEATH M		31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour) M	
29. To the best of my knowledge, death occurred at the time, date, place, and due to the cause(s) and manner stated. (Signature) <i>Arman Euroghi</i>				32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place, and due to the cause(s) and manner stated. (Signature)			
30. DATE SIGNED (Month, Day, Year) 10/27/05				33. DATE SIGNED (Month, Day, Year) COUNTY			
34. NAME, TITLE, ADDRESS AND ZIP CODE OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Arman Euroghi MD. 2801 N Gantenbein, Portland OR 97227							
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)							
36. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c). Do not enter mode of dying (e.g., Cardiac or Respiratory Arrest). PART I (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.							
40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Investigation Pending <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Legal Intervention <input type="checkbox"/> Homicide		41a. DATE OF INJURY (Month, Day, Year)		41b. TIME OF INJURY M		41c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
41e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		41d. DESCRIBE HOW INJURY OCCURRED					
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
37. Did tobacco use contribute to the death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown		38. AUTOPSY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		39. IF YES, were findings considered in determining cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A			

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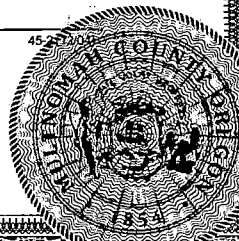
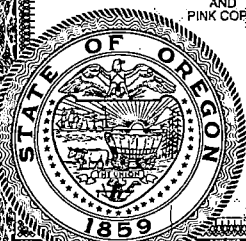
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DATE ISSUED:

NOV 08 2005

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Lila Wickham RN MS
LILA WICKHAM, RN, MS
COUNTY REGISTRAR
MULTNOMAH COUNTY, OREGON



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