



WHEN RECORDED RETURN TO:

Thomas A. Bennison

2956 NE 28th

Portland, OR 97212

Please print or type information **Washington State Recorder's Cover Sheet** (RCW 65.04)

DOCUMENT TITLE(S) (or transaction contained therein) (all areas applicable to your document must be filled in)

death cert

REFERENCE NUMBER(S) of Documents assigned or released:

Additional numbers on page _____ of document. 2018-002321

GRANTOR(S):

- 1. ~~deceased~~
- 2. Pat L. Wright
- 3. _____
- 4. _____

Additional names on page _____ of document.

SKAMANIA COUNTY
REAL ESTATE EXCISE TAX

GRANTEE(S):

- 1. Thomas A. Bennison
- 2. N/A
MAR 24 2026
- 3. _____
- 4. PAID N/A

Additional names on page _____ of document.

PAID
Max Monast
SKAMANIA COUNTY TREASURER

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

Complete legal on page _____ of document.

9600 00 83 00 0000
2M 3/24/26

Assessor's Property Tax Parcel #

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.

"I am signing below and paying an additional \$50.00 recording fee (as provided in RCW 36.18.010 and referred to as an emergency nonstandard document), because this document does not meet margin and formatting requirements. Furthermore, I hereby understand that the recording process may cover up or otherwise obscure some part of the text of the original document as a result of this request."

Signature of Requesting Party

Note to Submitter: Do NOT sign above nor pay additional \$50 fee if the document meets margin/formatting requirements.

CERTIFICATION OF VITAL RECORD

#D-3230
I. D. TAG NO.

OREGON STATE HEALTH DIVISION
DEPARTMENT OF HUMAN RESOURCES

Vital Records Unit

CERTIFICATE OF DEATH

136-

State File Number

Local File Number

DECEDENT

1. DECEDENT'S NAME First: Pat Middle: L. Last: WRIGHT			2. SEX M	3. DATE OF DEATH (Month, Day, Year) October 29, 1988		
4. SOCIAL SECURITY NUMBER		5a. AGE - Last Birthday (Year) 41	5b. UNDER 1 YEAR Mos. Days	5c. UNDER 1 DAY Hours Mins.	6. BIRTHPLACE (City and State or Foreign Country) Prairrie City, Oregon	7. DATE OF BIRTH (Month, Day, Year) March 17, 1947
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			9a. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Decedent's Residence <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) Good Samaritan 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.) Policeman		10b. KIND OF BUSINESS/INDUSTRY Federal Government		11. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		12. SPOUSE (If Married, Widowed) Gail P.
13a. RESIDENCE - STATE Oregon		13b. COUNTY Multnomah		13c. CITY, TOWN, OR LOCATION Portland		13d. STREET AND NUMBER 3202 N.E. 28th Ave.
13e. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13i. ZIP CODE 97212		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 Specify:		15. RACE American Indian, Black, White, etc. (Specify) white
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)						

PARENTS

17. FATHER - NAME first middle last Leonard Wright			18. MOTHER - NAME first middle maiden Tommy Ione McDonald			19. INFORMANT - NAME and relationship to deceased Gail Wright - wife
20a. METHOD OF DISPOSITION <input type="checkbox"/> Mausoleum <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <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) Rose City Crematorium		20c. LOCATION - City or Town, State Portland, Oregon	

DISPOSITION

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Charlotta Zeller</i>		21b. LICENSE NUMBER (Of Licensee) 0144	22. NAME, ADDRESS AND ZIP OF FACILITY Zeller Chapel of the Roses 2107 N.E. Broadway, Portland, OR 97232		
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CERTIFIER

TO BE COMPLETED BY CERTIFYING PHYSICIAN		TO BE COMPLETED ONLY BY MEDICAL EXAMINER			
23. TIME OF DEATH 1:50 A M		24. WAS MEDICAL EXAMINER NOTIFIED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27a. TIME OF DEATH M	
25. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) stated. (Signature) <i>Robert Ironside</i>		28. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) stated. (Signature)			
26. DATE SIGNED (Month, Day, Year) 11/1/88		29. DATE SIGNED (Month, Day, Year)		COUNTY	
30. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER (Type or Print) Robert Ironside, M.D., 2049 N.W. Hoyt, Portland, Oregon 97209					
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)					

CAUSE OF DEATH

32. 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.)			Interval between onset and death		
PART I (a) Miscellaneous Infarction			Interval between onset and death		
DUE TO, OR AS A CONSEQUENCE OF:			Interval between onset and death		
(b) Coronary Artery Disease			Interval between onset and death		
DUE TO, OR AS A CONSEQUENCE OF:			Interval between onset and death		
PART II (c) OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a)			33. AUTOPSY <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
			34. If YES were findings considered in determining cause of death? No		

REGISTRAR

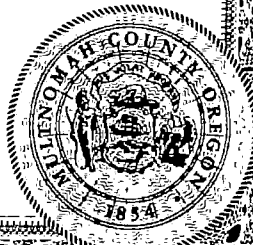
35. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined Manner <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		36a. DATE OF INJURY (Month, Day, Year)		36b. TIME OF INJURY	36c. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	36d. DESCRIBE HOW INJURY OCCURRED	
		36e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		36f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
37. REGISTRAR'S SIGNATURE <i>Arthur W. Bloom</i>				38. DATE FILED (Month, Day, Year) NOV 07 1988			
39. DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				40. WAS GIFT MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			

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

NOV 07 1988

DATE ISSUED

Arthur W. Bloom
ARTHUR W. BLOOM
COUNTY REGISTRAR
MULTNOMAH COUNTY, OREGON



Unofficial
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