

Request of: THOMAS A BENNISON



**WHEN RECORDED RETURN TO:**

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Thomas A. Bennison

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2956 NE 28th Ave

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Port Inwa, 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

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**REFERENCE NUMBER(S)** of Documents assigned or released:  
 Additional numbers on page \_\_\_\_\_ of document. 2018-002321

**GRANTOR(S):**

1. ~~deceased~~ 2. Carol P. Wright

3. \_\_\_\_\_ 4. SKAMANIA COUNTY  
 REAL ESTATE EXCISE TAX

Additional names on page \_\_\_\_\_ of document. N/A

**GRANTEE(S):**

1. Thomas A. Bennison 2. MAR 24 2026

3. \_\_\_\_\_ 4. ~~PAID MONDAY~~ N/A ~~DEPOTS~~  
 SKAMANIA COUNTY TREASURER

Additional names on page \_\_\_\_\_ of document.

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

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Complete legal on page \_\_\_\_\_ of document. 96000083000000  
 Assessor's Property Tax Parcel # 2M 3/24/26

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

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

548941

I.D. TAG NO.:

STATE FILE NUMBER

\*189471\*

1. Legal Name First: Gail Middle: Patricia Last: Wright Suffix:			2. Death Date July 08, 2009	
3. Sex Female	4. Age 62 years	5. Social Security Number		6. County of Death Multnomah
7. Birthdate December 28, 1946		8. Birthplace Houma, Louisiana		9. Decedent's Education Some college
10. Was Decedent of Hispanic Origin? No		11. Decedent's Race(s) White		12. Was Decedent Ever in U.S. Armed Forces? No
13. Residence: Number and Street 3202 NE 28th Avenue			14. City/Town Portland	
15. Residence County Multnomah	16. State or Foreign Country Oregon	17. Zip Code + 4 97212	18. Inside City Limits? Yes	
19. Marital Status at Time of Death Widowed		20. Spouse's Name Prior to First Marriage Pat Wright		
21. Usual Occupation Homemaker		22. Kind of Business/Industry Her own home		
23. Father's Name Ells Picou		24. Mother's Name Prior to First Marriage Patricia Kruse		
25. Informant's Name Thomas Bennison		26. Telephone Number Not Available	27. Relationship to Decedent Son	28. Mailing Address 2956 NE 28th Avenue, Portland, OR 97212
29. Place of Death Hospital-Inpatient		30. Facility Name Legacy Emanuel Hospital & Health Center		
31. Location of Death 2801 N Gantenbein		32. City/Town or Location of Death Portland		33. State Oregon
34. Zip Code + 4 97227		37. Location Tualatin, Oregon		
35. Method of Disposition Cremation		36. Place of Disposition Cascade Cremation Center		37. Location Tualatin, Oregon
38. Name and Complete Address of Funeral Facility Crown Memorial Center - Cremation & Burial (Milwaukie) 17064 SE McLoughlin Boulevard, Milwaukie, Oregon 97267				
39. Date of Disposition TBD		40. Funeral Director's Signature Bruce D. Fuller		41. OR License Number FS-0496
42. Registrar's Signature <i>[Signature]</i>		43. Date Received JUL 20 2009		44. Local File Number 1153
45. Amendment				
46. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		47. Autopsy? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	48. Were autopsy findings available to complete the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
CAUSE OF DEATH				
49. Time of Death Onset to Death 1629 hrs				49. Time of Death Onset to Death 1629 hrs
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.				
Final disease or condition resulting in death →		IMMEDIATE CAUSE ↓		Approximate Interval: Onset to Death
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).		Bacterial Meningitis		40 hours
Due to (or as a consequence of) ↓				
Due to (or as a consequence of) ↓				
Due to (or as a consequence of) ↓				
51. Other significant conditions contributing to death, but not resulting in the underlying cause given above. Hypoxic Brain Injury; history of Pulmonary Emboli (c possible acute P.E. on autopsy)				
52. Manner of Death		53. If Female		54. Did tobacco use contribute to 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		<input type="checkbox"/> Not pregnant within past year <input checked="" 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		<input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
55. Date of Injury (MM/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 type="checkbox"/> No <input type="checkbox"/> Unknown
59. Location of Injury (Number & Street or RFD No., 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 or RFD No., City/Town, State, Zip + 4) Jason Leong 2282 NW Northrup St., Ste. 42, Portland, OR 97210				
63. Name and Title of Attending Physician if Other than Certifier				
64. Title of Certifier D.O.		65. License Number D026699	66. Date Signed (MM/DD/YYYY) 7/14/2009	
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. Amendment				

45-2DP (01/06)

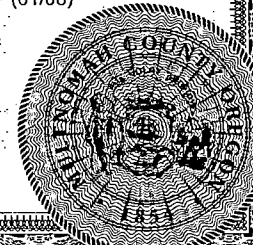
THIS IS A TRUE AND EXACT REPRODUCTION OF THE DOCUMENT OFFICIALLY REGISTERED AT THE OFFICE OF THE MULTNOMAH COUNTY REGISTRAR.

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

DATE ISSUED:

JUL 20 2009

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



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