73072

OREGON HEALTH DIVISION
CENTER FOR HEALTH STATISTICS

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STATE OF OREGON
OREGON STATE HEALTH DIVISION
DEPARTMENT OF HUMAN SERVICES
Vital Records Unit

27071 STATE NO. 06154 Local File Number

86-021898 State File Number

CERTIFICATE OF DEATH

DECEASED—NAME (First, Middle, Last): JAQUELINE LANN HUTCHCRAFT

DATE OF DEATH (month, day, year): DECEMBER 17, 1986

RACE (White, Black, American Indian, etc. (specify)): White

SEX: Female

AGE (Last Birthday) (Years): 32

If Under 1 Year: Months / Days / Hours / Minutes

If Under 24 Hours: Minutes

DATE OF BIRTH (month, day, year): February 19, 1954

CITY, TOWN OR LOCATION OF DEATH: Portland

HOSPITAL OR OTHER INSTITUTION—NAME (If not in either, give street and number): UNIVERSITY HOSPITAL SOUTH

If Hospital or Institution—Inpatient or ER/Outpatient or DOA: INPATIENT

COUNTY OF DEATH: MULTNOMAH

STATE OF BIRTH (If not in U.S.A., name country): Oregon

CITIZEN OF WHAT COUNTRY: USA

MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

SPOUSE (If married, widowed or divorced—name): Steven A.

WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify yes or no): No

SOCIAL SECURITY NUMBER: 542-64-3297

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

KIND OF BUSINESS OR INDUSTRY: Own Home

RESIDENCE—STATE: Oregon

COUNTY: Washington

CITY, TOWN OR LOCATION: Hillsboro

STREET AND NUMBER OR R.F.D.: 7046 NE Stresss

ZIP: 97124

Inside City Limits (Specify yes or no): Yes

FATHER—NAME (First, Middle, Last): Hendleo Schneider

MOTHER (Maiden Name) (First, Middle, Last): Ella Mae Vandehey

INFORMANT—NAME and relationship to deceased: Steven A. Hutchcraft, husband

BURIAL, CREMATION, REMOVAL, MAUS. (Specify): Burial

CEMETERY OR CREMATORY—NAME: St. Francis Cemetery

LOCATION (City or town, State): Roy, Oregon

FUNERAL SERVICE LICENSEE or person acting as such (Signature): Lisa Marsh

NAME AND ADDRESS OF FACILITY: Doerfler, Sewell and Mathews, 971 NE 3rd, Hillsboro, Oregon 97124

To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.

DATE SIGNED (Mo., Day, Year): 12/19/86

HOUR OF DEATH: 1:22 P.M.

Signature: Kimberly A. Henry

NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print): Kimberly A. Henry MD, 3181 SW Sam Jackson Park Road, Portland, Oregon 97201

NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print): Dr. Edward Wenwitt

DATE RECEIVED BY REGISTRAR (Mo., Day, Year): DEC 22 1986

REGISTRAR (Signature): [signature]

PART I. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c).)

(a) Brain stem infarction — Interval between onset and death: 24 hours

DUE TO, OR AS A CONSEQUENCE OF:

(b) Primary central nervous system glioblastoma — Interval between onset and death: months

DUE TO, OR AS A CONSEQUENCE OF:

(c)

PART II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I(a).

AUTOPSY (Specify Yes or No): Yes

WAS MEDICAL EXAMINER NOTIFIED? (Specify Yes or No): Yes

ACCIDENT (Specify Yes or No)

DATE OF INJURY (Mo., Day, Year)

HOUR OF INJURY

DESCRIBE HOW INJURY OCCURRED

INJURY AT WORK (Specify Yes or No)

PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)

LOCATION—STREET OR R.F.D. NO. / CITY OR TOWN / STATE

DID HOSPITAL REPRESENTATIVE MAKE REQUEST FOR ANATOMICAL GIFT CONSENT? Yes ☒ No ☐ N/A ☐

WAS GIFT MADE? Yes ☐ No ☐ N/A ☐

RESERVED FOR REGISTRAR'S USE

ORIGINAL—VITAL STATISTICS COPY

UPON RECORDING, PLEASE RETURN TO: Steven A. Hutchcraft General Delivery, Stayton OR 97383

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE IN THE VITAL RECORDS UNIT OF THE OREGON STATE HEALTH DIVISION.

DEC 17 1993
DATE ISSUED

Edward J. Johnson
EDWARD J. JOHNSON, M.D.