

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CERTIFIED COPY OF DEATH CERTIFICATE

TYPE OR PRINT IN PERMANENT BLACK INK

3782

LOCAL FILE NUMBER



CERTIFICATE OF DEATH

146

STATE FILE NUMBER

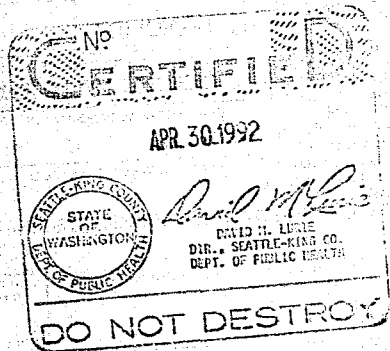
1. NAME First Middle Last STANLEY BEARD SOLEM			2. SEX (M / F) M	3. DEATH DATE (Mo. Day, Yr) APRIL 19, 1992	
4. AGE LAST BIRTH DAY (Yrs) 66	5. UNDER 1 YEAR MOS DAYS	6. UNDER 1 DAY HOURS MINS	7. BIRTH DATE (Mo. Day, Yr) JUNE 27, 1925		8. BIRTH PLACE (City, State or Foreign Country) HETTINGER, N.D.
11. CITY, TOWN OR LOCATION OF DEATH SEATTLE			12. PLACE OF DEATH—BY BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1. HOME 2. IN TRANSPORT 3. CARE FACILITY 4. HOSP. 5. NUR HOME 6. OTHER PLACE 4. VETERANS ADMINISTRATION MEDICAL CENTER		13. SMOKING IN LAST 15 YEARS? (Yes / No) NO
14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) MARRIED		15. SURVIVING SPOUSE (if wife, give maiden name) DORIS MAE WARD		16. SOCIAL SECURITY NO. 542-26-6749	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12
18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) TRUCK DRIVER		19. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes / No) Specify: WHITE	
22. RESIDENCE—NUMBER AND STREET 707 37TH ST SE, SP 62		23. CITY/TOWN OR LOCATION AUBURN	24. INSIDE CITY LIMITS? (Yes / No) YES	25A. COUNTY KING	25B. LENGTH OF RES. IN CO. 40 YRS
26. FATHER'S NAME—FIRST, MIDDLE, LAST JOACHEM SOLEM		27. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME AAGAT PAULINE PETERSON		28. ZIP CODE 98002	
30. INFORMANT—NAME DORIS SOLEM		31. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP 707 37TH ST SE, SP 62, AUBURN, WA 98002		32. BIRTH DATE (Mo. Day, Yr) 4/23/92	
33. BIRTH PLACE (City, State or Foreign Country) Mountain View Cemetery		34. CEMETERY/CREMATORY—NAME Mountain View Cemetery		35. LOCATION—CITY/TOWN, STATE Auburn Washington	
36. FUNERAL DIRECTOR SIGNATURE <i>Raymond Price</i>		37. NAME OF FACILITY Price-Helton Funeral Chapel		38. ADDRESS OF FACILITY P.O. Box 9, Auburn, WA 98071	
39. TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED: SIGNATURE AND TITLE <i>Gregory Thompson M.D.</i>			40. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE <i>Gregory Thompson M.D.</i>		
41. DATE SIGNED (Mo., Day, Yr) APRIL 19, 1992		42. HOUR OF DEATH (24 Hrs.) 1355		43. DATE SIGNED (Mo., Day, Yr)	
44. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) SARAH LYLE, M.D.		45. HOUR PRONOUNCED DEAD (24 Hrs.)		46. HOUR PRONOUNCED DEAD (24 Hrs.)	
47. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) GREGORY THOMPSON, M.D., VAMC, 1660 S COLUMBIAN WAY, SEATTLE, WA 98108		48. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)		49. RECORDS FILE NUMBER	
50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		A. INFECTION		INTERVAL BETWEEN ONSET AND DEATH 1 WK	
DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.		B. CHRONIC MYELOGENOUS LEUKEMIA		INTERVAL BETWEEN ONSET AND DEATH 9 YRS	
		C.		INTERVAL BETWEEN ONSET AND DEATH	
		D.		INTERVAL BETWEEN ONSET AND DEATH	
51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE					
54. ACC. SUICIDE, HOM. UNDET. OR PENDING INVEST. (Specify) natural		55. INJURY DATE (Mo. Day, Yr)		56. HOUR OF INJURY (24 Hrs.)	
57. DESCRIBE HOW INJURY OCCURRED:		58. AUTOPSY? (Yes / No) NO		59. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No) NO	
60. INJURY AT WORK? (Yes / No) No		61. PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE, BLDG, ETC. (Specify)		62. LOCATION—STREET OR RFD NO., CITY/TOWN, STATE	
63. RECORD AMENDMENT (Registrar use only) ITEM DOCUMENTARY EVIDENCE REVIEWED BY DATE		64. REGISTRAR SIGNATURE <i>S. Lyle</i>		65. DATE RECEIVED (Mo., Day, Yr) APR 28 1992	

THIS IS A COPY OF THE ORIGINAL RECORD. RECORDS ON FILE WITH VITAL RECORDS. CERTIFIED COPIES MUST BE OBTAINED FROM THE ORIGINAL RECORDS.

SAV

OFFICE OF HEALTH

(Faint, mostly illegible text from a form, possibly a health certificate or record, with some words like 'CERTIFIED' and 'DO NOT DESTROY' visible in the background.)



148397 H

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of _____ the _____ 8th day
 of _____ August _____ A.D., 19 97 at 3:31 o'clock _____ P. M., and duly recorded in Vol. M97
 of _____ Deeds _____ on Page 26168.

FEE \$10.00

By Bernetha G. Letsch County Clerk
(Signature)