

OFFICE
USE
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TYPE OR PRINT IN PERMANENT BLACK INK



CERTIFICATE OF DEATH

1435

LOCAL FILE NUMBER

146 7 21186

STATE FILE NUMBER

1. DISTRICT

2. COPIES

3. HOSPITAL

4. OCCURRENCE

5. RESIDENCE

6. TRACT

7. OCCUPATION

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21. ACC LOC

22. QUERIES

23.

24.

1. NAME First Middle Last STANLEY TASTAD				2. SEX (M / F) MALE		3. DEATH DATE (Mo. Day, Yr) JUNE 14, 1997													
4. AGE LAST BIRTH-DAY (Yrs) 77		5. UNDER 1 YEAR MOS DAYS 		6. UNDER 1 DAY HOURS MINS 		7. BIRTHDATE (Mo. Day, Yr) MAY 8, 1920		8. BIRTHPLACE (City, State or Foreign Country) LAKE STEVENS, WA.		9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No) NO		10. COUNTY OF DEATH SNOHOMISH							
11. CITY, TOWN OR LOCATION OF DEATH STANWOOD				12. PLACE OF DEATH— <input checked="" type="checkbox"/> BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1. <input type="checkbox"/> HOME 2. <input type="checkbox"/> IN TRANSPORT 3. <input type="checkbox"/> EMERG. RM/OUT PTN 4. <input type="checkbox"/> HOSP. 5. <input checked="" type="checkbox"/> NUR HOME 6. <input type="checkbox"/> OTHER PLACE JOSEPHINE SUNSET HOME								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) DAISY KOPLITZ				16. SOCIAL SECURITY NO. 720-18-2146				17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 -0-							
18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) FARMER				19. KIND OF BUSINESS OR INDUSTRY CHICKENS				20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify: NO				21. RACE (Specify) WHITE							
22. RESIDENCE—NUMBER AND STREET 9901 272nd Pl. N.W.				23. CITY/TOWN, OR LOCATION STANWOOD		24. INSIDE CITY LIMITS? (Yes / No) YES		25A. COUNTY SNOHOMISH		25B. LENGTH OF RES. IN CO. 77 YRS		26. STATE WASH		27. ZIP CODE 98292					
28. FATHER'S NAME—FIRST, MIDDLE, LAST BERTRUM TASTAD								29. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME SARAH TAKLO											
30. INFORMANT—NAME RON CLAUSEN								31. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP P.O.# 453 LAKE STEVENS, WASHINGTON 98258											
32. BURIAL, CREMATION REMOVAL, OTHER (Specify) CREMATION				33. DATE (Mo. Day, Yr) 6/18/97				34. CEMETERY/CREMATORY—NAME MT. VERNON CEMETERY				35. LOCATION—CITY/TOWN, STATE MT. VERNON, WASHINGTON							
36. FUNERAL DIRECTOR SIGNATURE <i>John R. Samuel</i>				37. NAME OF FACILITY GILBERTSON FUNERAL HOME				38. ADDRESS OF FACILITY STANWOOD, WASHINGTON											
TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN								TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER											
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 X <i>Steven W. Luther M.D.</i>								43. 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 X											
40. DATE SIGNED (Mo., Day, Yr) 6/16/97				41. HOUR OF DEATH (24 Hrs.) 22:00				44. DATE SIGNED (Mo., Day, Yr)				45. HOUR OF DEATH (24 Hrs.)							
42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)								46. PRONOUNCED DEAD (Mo., Day, Yr)				47. HOUR PRONOUNCED DEAD (24 Hrs.)							
48. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) DR. STEVEN W. LUTHER M.D. STANWOOD FAMILY HEALTH CARE CENTER, STANWOOD, WA.								49. ME/CORONER FILE NUMBER											
50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:																			
IMMEDIATE CAUSE (Final disease or condition resulting in death). 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.												A. <i>Cerebral anoxia</i>				INTERVAL BETWEEN ONSET AND DEATH 5 min			
												B. <i>respiratory arrest</i>				INTERVAL BETWEEN ONSET AND DEATH 5 min			
												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:												52. AUTOPSY? (Yes / No) NO				53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No) NO			
54. ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)				55. INJURY DATE (Mo. Day, Yr)				56. HOUR OF INJURY (24 Hrs)				57. DESCRIBE HOW INJURY OCCURRED:							
58. INJURY AT WORK? (Yes / No)				59. PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE BLDG, ETC. (Specify)				60. LOCATION—STREET OR RFD NO., CITY/TOWN, STATE											
61. RECORD AMENDMENT (Registrar use only) ITEM DOCUMENTARY EVIDENCE REVIEWED BY DATE				62. REGISTRAR SIGNATURE X <i>Doris E. Peterson</i>				63. DATE RECEIVED (Mo., Day, Yr.) 6-17-97											

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

DOH 110-008 (Rev. 7/91) (formerly DSHS 9-150)

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