OFFICE USE ONLY
1. DISTRICT
2. COPIES
3. HOSPITAL
4. OCCURRENCE
5. RESIDENCE
6. TRACT
7. OCCUPATION
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.
21. ACC LOC
22. QUERIES
23.
24.

TYPE OR PRINT IN PERMANENT BLACK INK

1178
LOCAL FILE NUMBER

Washington State Department of Health

CERTIFICATE OF DEATH

1468 42392
STATE FILE NUMBER

DECEDENT

1. NAME First	Middle	Last	2. SEX (M / F)	3. DEATH DATE (Mo, Day, Yr)
SADIE		RADDER	FEMALE	12/22/1998

4. AGE LAST BIRTHDAY (Yrs)	5. UNDER 1 YEAR MOS	DAYS	6. UNDER 1 DAY HOURS	MINS	7. BIRTHDATE (Mo, Day, Yr)	8. BIRTHPLACE (City, State or Foreign Country)	9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No)	10. COUNTY OF DEATH
93					1-18-1905	LYNDEN, WA	NO	WHATCOM

11. CITY, TOWN OR LOCATION OF DEATH	12. PLACE OF DEATH—☒ BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1. ☒ HOME 2. ☐ IN TRANSPORT 3. ☐ EMERG. RM/OUT PTN 4. ☐ HOSP. 5. ☐ NUR HOME 6. ☐ OTHER PLACE	13. SMOKING IN LAST 15 YEARS? (Yes / No)
SUMAS	3259 CLEARBROOK ROAD	NO

14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (if wife, give maiden name)	16. SOCIAL SECURITY NO.	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
WIDOWED		539-36-5402	8	

18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)	19. KIND OF BUSINESS OR INDUSTRY	20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify:	21. RACE (Specify)
HOMEMAKER	OWN HOME	NO	WHITE

22. RESIDENCE—NUMBER AND STREET	23. CITY/TOWN, OR LOCATION	24. INSIDE CITY LIMITS? (Yes / No)	25A. COUNTY	25B. LENGTH OF RES. IN CO.	26. STATE	27. ZIP CODE
3259 CLEARBROOK RD.	SUMAS	NO	WHATCOM	93yrs	WA	98295

PARENTS

28. FATHER'S NAME—FIRST, MIDDLE, LAST	29. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
THOMAS HEERINGA	ZENA ASSINK

30. INFORMANT—NAME	31. MAILING ADDRESS STREET OR RFD NO.	CITY OR TOWN	STATE	ZIP
BETTY ENGLER	6132 GADWA ROAD	FERNDALE,	WA	98248

DISPOSITION

32. BURIAL, CREMATION REMOVAL, OTHER (Specify)	33. DATE (Mo, Day, Yr)	34. CEMETERY/CREMATORY—NAME	35. LOCATION—CITY/TOWN, STATE
BURIAL	12/26/1998	MONUMENTA CEMETERY	LYNDEN, WA

36. FUNERAL DIRECTOR SIGNATURE	37. NAME OF FACILITY	38. ADDRESS OF FACILITY
X Donalee Smith	GILLIES FUNERAL HOME	202 Front Street LYNDEN, WA

CERTIFIER

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 [signature]	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)	41. HOUR OF DEATH (24 Hrs.)	44. DATE SIGNED (Mo., Day, Yr)	45. HOUR OF DEATH (24 Hrs)
12/22/98	0320		
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)	49. ME/CORONER FILE NUMBER
DANIEL AUSTIN, MD 3015 SQUALICUM PKWY BELLINGHAM, WA	

CAUSE OF DEATH

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.

		INTERVAL BETWEEN ONSET AND DEATH
A.	liver cancer / metastatic	
DUE TO, OR AS A CONSEQUENCE OF: B.	probable colon cancer primary	
DUE TO, OR AS A CONSEQUENCE OF: C.		
DUE TO, OR AS A CONSEQUENCE OF: D.		

51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE:	52. AUTOPSY? (Yes / No)	53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No)
	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	63. DATE RECEIVED (Mo., Day, Yr.)
				X [signature]	12-23-98

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

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

A