

196
LOCAL FILE NUMBER

CERTIFICATE OF DEATH

D E C E D E N T	1. NAME—FIRST, MIDDLE, LAST MARIE J. MacDONALD				2. SEX FE	3. DEATH DATE (Mo., Day, Yr.) Jan. 25, 1988		146-8 8 00833 STATE FILE NUMBER																																													
	4. AGE—LAST BIRTH- DAY (Yrs.) 93	5. UNDER 1 YEAR MOS. DAYS	6. UNDER 1 DAY HOURS MINS.	7. BIRTHDATE (Mo., Day, Yr.) Mar 19, 1894		8. COUNTY OF DEATH Snohomish																																															
	9. CITY, TOWN OR LOCATION OF DEATH Everett			10. 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 Virginia Manor Convalescent Center				11. BIRTH STATE (If not in USA, give country) French Possession																																													
	12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		13. SPOUSE (If Wife give Maiden Surname) N/R		14. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No) No		15. SOCIAL SECURITY NO. 574-03-5286		16. HIGH SCHOOL GRADUATE (Yes/No) U																																												
P A R E N T S	17. USUAL OCCUPATION (Give kind of work done during most of working life even if retired.) Homemaker			18. KIND OF BUSINESS OR INDUSTRY Own home		19. RACE (White, Black, Am. Ind., etc. Specify) White		20. Was Decedent of Hispanic Origin? (specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. <input type="checkbox"/> Yes 2. <input checked="" type="checkbox"/> No (specify)																																													
	21. SMOKING IN LAST 15 YEARS (Yes/No) U		22. RESIDENCE—NUMBER AND STREET 3515 Hoyt		23. CITY/TOWN, OR LOCATION Everett		24. INSIDE CITY LIMITS? (Yes/No) Yes		25. COUNTY Snohomish																																												
							26. STATE WA.		27. ZIP CODE 98203																																												
	28. FATHER'S NAME—FIRST, MIDDLE, LAST U Desdouets				29. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME U U																																																
D I S P O S I T I O N	30. INFORMANT—NAME Robert MacDonald			31. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP 2019 Fairlane Rd. Bel Air, Maryland																																																	
	32. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial/Removal		33. DATE (Mo., Day, Yr.) 1-28-88		34. CEMETERY/CREMATORY—NAME Loudon National Cemetery			35. LOCATION—CITY/TOWN, STATE Baltimore, Maryland																																													
	36. FUNERAL DIRECTOR SIGNATURE X [Signature]		37. NAME OF FACILITY Solie Funeral Home			38. ADDRESS OF FACILITY 3301 Colby Avenue Everett, Washington 98201																																															
	<table border="1"> <tr> <th colspan="5">TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN</th> <th colspan="4">TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER</th> </tr> <tr> <td colspan="5">39. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, AND PLACE AND DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X [Signature] MD</td> <td colspan="4">43. 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) STATED. SIGNATURE AND TITLE X</td> </tr> <tr> <td colspan="3">40. DATE SIGNED (Mo., Day, Yr.) 1/27/88</td> <td colspan="2">41. HOUR OF DEATH (24 Hrs.) 2400</td> <td colspan="3">44. DATE SIGNED (Mo., Day, Yr.)</td> <td>45. HOUR OF DEATH (24 Hrs.)</td> </tr> <tr> <td colspan="5">42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)</td> <td colspan="3">46. PRONOUNCED DEAD (Mo., Day, Yr.)</td> <td>47. HOUR PRONOUNCED DEAD (24 Hrs.)</td> </tr> <tr> <td colspan="9">48. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) Dr. Bruce E. Main, 4225 Hoyt Avenue, Everett, Washington 98201</td> </tr> </table>									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 DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X [Signature] MD					43. 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) STATED. SIGNATURE AND TITLE X				40. DATE SIGNED (Mo., Day, Yr.) 1/27/88			41. HOUR OF DEATH (24 Hrs.) 2400		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. Bruce E. Main, 4225 Hoyt Avenue, Everett, Washington 98201							
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C A U S E O F D E A T H	49. PART I. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE 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.																																																				
	IMMEDIATE CAUSE (Final disease or condition resulting in death). Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST			(A) Atherosclerotic cardiovascular disease					INTERVAL BETWEEN ONSET AND DEATH years																																												
				(B) DUE TO, OR AS A CONSEQUENCE OF:					INTERVAL BETWEEN ONSET AND DEATH																																												
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50. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN ABOVE Cardiac valvular disease							51. AUTOPSY? (Yes, No) No		52. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No) No																																												
53. ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)		54. INJURY DATE (Mo., Day, Yr.)		55. HOUR OF INJURY (24 Hrs.)		56. DESCRIBE HOW INJURY OCCURRED																																															
57. INJURY AT WORK? (Yes/No)		58. PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE BLDG. ETC. (Specify)			59. LOCATION—STREET OR RFD NO., CITY/TOWN, STATE																																																
60. REGISTRAR SIGNATURE X [Signature] MD								61. DATE RECEIVED (Mo., Day, Yr.) JAN 27 1988																																													
62. ITEM 3 D/A #00197 JP 8-4-88		DOCUMENTARY EVIDENCE:		REVIEWED BY:		DATE:		63. ITEM																																													
FOR STATE REGISTRAR USE ONLY		DOCUMENTARY EVIDENCE:		REVIEWED BY:		DATE:																																															