

## CERTIFICATE OF DEATH

1 13322

1281  
LOCAL FILE NUMBER

146

STATE FILE NUMBER

1 DISTRICT  
A1-1  
2 COPIES  
3 HOSPITAL  
4 OCCURRENCE  
5 RESIDENCE  
6 TRACT  
046  
7 OCCUPATION  
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21 ACC LOC  
22 QUERIES  
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DECEDENT

PARENTS

DISPOSITION

CERTIFIER

CAUSE OF DEATH

|  |  |  |  |  |  |  |  |   |                                  |                                       |  |  |  |
|--|--|--|--|--|--|--|--|---|----------------------------------|---------------------------------------|--|--|--|
| 1 NAME—FIRST, MIDDLE, LAST<br>OLIVE MAIREEN GROBEL   |  |  |  | 2 SEX<br>FEMALE  |  | 3 DEATH DATE (Mo., Day, Yr.)<br>APR 30, 1991   |  | 146   |                                  | STATE FILE NUMBER                     |  |  |  |
| 4 AGE LAST BIRTH-DAY (Yrs.)<br>81  |  | 5 UNDER 1 YEAR<br>MOS. DAYS  |  | 6 UNDER 1 DAY<br>HOURS MINS.   |  | 7 BIRTHDATE (Mo., Day, Yr.)<br>DEC 14, 1909  |  | 8 BIRTH STATE (if not in USA give country)<br>WASHINGTON  |                                  | 9 CITIZEN OF WHAT COUNTRY?<br>USA     |  | 10 COUNTY OF DEATH<br>SPOKANE  |  |
| 11 CITY, TOWN OR LOCATION OF DEATH<br>SPOKANE  |  |  |  |  |  | 12 PLACE OF DEATH — <input checked="" type="checkbox"/> BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME<br>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<br>ROCKWOOD MANOR |  |   |                                  |                                       |  | 13 SMOKING IN LAST 15 YEARS? (Yes/No)<br>NO  |  |
| 14 MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify)<br>NEVER MARRIED   |  |  |  | 15 SURVIVING SPOUSE (If wife, give maiden name)  |  |  |  | 16 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No)<br>NO   |                                  | 17 SOCIAL SECURITY NO.<br>536-30-4590 |  | 18 HIGH SCHOOL GRADUATE? (Yes/No)<br>YES   |  |
| 19 USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)<br>TEACHER/LIBRARIAN  |  |  |  | 20 KIND OF BUSINESS OR INDUSTRY<br>MUSIC/HIGHER ED.  |  |  |  | 21 Was Decedent of Hispanic Origin or descent? (Ancestry) (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.)<br>1. <input type="checkbox"/> Yes 2. <input checked="" type="checkbox"/> No |                                  |                                       |  | 22 RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc. (Specify))<br>WHITE |  |
| 23 RESIDENCE - NUMBER AND STREET<br>EAST 2903 25TH   |  |  |  | 24 CITY/TOWN, OR LOCATION<br>SPOKANE   |  | 25 INSIDE CITY LIMITS? (Yes/No)<br>YES   |  | 26 COUNTY<br>SPOKANE  |                                  | 27 STATE<br>WASHINGTON                |  | 28 ZIP CODE<br>99223   |  |
| 29 FATHER'S NAME—FIRST, MIDDLE, LAST<br>EDWARD GROBEL  |  |  |  |  |  | 30 MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME<br>BESS BARKER  |  |   |                                  |                                       |  |  |  |
| 31 INFORMANT—NAME<br>WINIFRED A. ROOT  |  |  |  | 32 MAILING ADDRESS<br>STREET OR RFD NO. CITY OR TOWN STATE ZIP<br>2012 BAYVIEW MORRO BAY, CALIFORNIA 93442 |  |  |  |   |                                  |                                       |  |  |  |
| 33 BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br>CREMATION  |  | 34 DATE (Mo., Day, Yr.)<br>MAY 1, 1991   |  | 35 CEMETERY/CREMATORY—NAME<br>HAZEN & JAEGER CREMATORIUM   |  |  |  | 36 LOCATION—CITY/TOWN, STATE<br>SPOKANE, WASHINGTON   |                                  |                                       |  |  |  |
| 37 FUNERAL/DIRECTOR SIGNATURE<br>X <i>Paul E. Mose</i>   |  |  |  | 38 NAME OF FACILITY<br>HAZEN & JAEGER FUNERAL HOME   |  |  |  | 39 ADDRESS OF FACILITY<br>NORTH 1306 MONROE STREET SPOKANE, WASHINGTON 99201  |                                  |                                       |  |  |  |
| TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN   |  |  |  |  |  | TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER  |  |   |                                  |                                       |  |  |  |
| 40. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE, AND PLACE AND DUE TO THE CAUSE(S) STATED<br>SIGNATURE AND TITLE<br>X <i>Keith Wilkens</i>   |  |  |  |  |  | 41. 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<br>SIGNATURE AND TITLE<br>X   |  |   |                                  |                                       |  |  |  |
| 42. DATE SIGNED (Mo., Day, Yr.)<br>4-30-91   |  |  |  | 43. HOUR OF DEATH (24 Hrs.)<br>0100  |  | 44. DATE SIGNED (Mo., Day, Yr.)  |  |   |                                  | 45. HOUR OF DEATH (24 Hrs.)           |  |  |  |
| 46. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)  |  |  |  |  |  | 47. PRONOUNCED DEAD (Mo., Day, Yr.)  |  |   |                                  | 48. HOUR PRONOUNCED DEAD (24 Hrs.)    |  |  |  |
| 49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print)<br>Keith Wilkens, MD S. 2921 Grand Blvd., Spokane, WA 99203   |  |  |  |  |  |  |  |   |                                  |                                       |  |  |  |
| 50. 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) <i>Cardiopulmonary Arrest</i>  |  |   | INTERVAL BETWEEN ONSET AND DEATH |                                       |  |  |  |
|  |  |  |  |  |  | (B) <i>Multiple Sclerosis</i>  |  |   | INTERVAL BETWEEN ONSET AND DEATH |                                       |  |  |  |
|  |  |  |  |  |  | (C)  |  |   | 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)<br>NO   |  | 53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No)<br>NO  |                                  |                                       |  |  |  |
| 54. ACC, SUICIDE, HO., 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. REGISTRAR SIGNATURE<br>X <i>Jan W. Gend. MD</i>  |  |  |  |  |  | 62. DATE RECEIVED (Mo., Day, Yr.)<br>MAY 01 1991   |  |   |                                  |                                       |  |  |  |