

## CERTIFICATE OF DEATH

9 28605

LOCAL FILE NUMBER

1 DISTRICT	1. NAME—FIRST, MIDDLE, LAST Daisy Pearl LEONARD			2 SEX F	3 DEATH DATE (Mo., Day, Yr.) Oct. 5, 1989		146	STATE FILE NUMBER	
2 COPIES	4. AGE LAST BIRTH-DAY (Yrs) 94	5 UNDER 1 YEAR MOS. DAYS	6 UNDER 1 DAY HOURS MINS	7. BIRTHDATE (Mo., Day, Yr.) 11/14/1894	8 BIRTH STATE (If not in USA give country) Oregon	9 CITIZEN OF WHAT COUNTRY? USA	10. COUNTY OF DEATH Yakima		
3 HO	11. CITY, TOWN OR LOCATION OF DEATH Yakima			12. PLACE OF DEATH — <input checked="" type="checkbox"/> BOX FOR PLACE THEN GIVE ADDRESS OF 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 type="checkbox"/> NUR HOME 6 <input type="checkbox"/> OTHER PLACE St. Elizabeth Medical Center (4)			13 SMOKING IN LAST 15 YEARS? (Yes/No) No		
4 OCCURRENCE	14. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) Divorced	15. SURVIVING SPOUSE (If wife, give maiden name) -----		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No) No	17. SOCIAL SECURITY NO. 534-14-6059A		18. HIGH SCHOOL GRADUATE? (Yes/No) No		
5 RESIDENCE	19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) Homemaker		20. KIND OF BUSINESS OR INDUSTRY Own Home		21. Was Decedent of Hispanic Origin or descent? (Ancestry) (Specify Yes or No. If Yes specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		22. RACE (White, Black, Asian or Pacific Islander, Am. Ind., Hispanic, etc) (Specify) White		
6 TRACT	23. RESIDENCE - NUMBER AND STREET 320 Thornton Lane		24. CITY/TOWN, OR LOCATION Yakima	25. INSIDE CITY LIMITS? YES	26. COUNTY Yakima	27. STATE WA	28. ZIP CODE 98901		
7 OCCUPATION	29. FATHER'S NAME—FIRST, MIDDLE, LAST Unknown				30. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME Clementine Green				
8	31. INFORMANT—NAME Audrey Spencer			32. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP 320 Thornton Lane, Yakima, WA 98901					
9	33. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial	34. DATE (Mo., Day, Yr.) 10/11/1989	35. CEMETERY/CREMATORY—NAME West Hills			36. LOCATION—CITY/TOWN, STATE Yakima, WA			
10	37. FUNERAL DIRECTOR SIGNATURE <i>[Signature]</i>		38. NAME OF FACILITY Shaw & Sons Memorial Chapel			39. ADDRESS OF FACILITY 89807 P.O. Box 2648, Yakima, WA			
11	<b>TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN</b>				<b>TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER</b>				
12	40. 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 Roger L. Bracchi MD				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. SIGNATURE AND TITLE X				
13	42. DATE SIGNED (Mo., Day, Yr.) 10/9/89		43. HOUR OF DEATH (24 Hrs) 2133 HRS		44. DATE SIGNED (Mo., Day, Yr.)		45. HOUR OF DEATH (24 Hrs)		
14	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)		
15	49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) Roger L. Bracchi, M.D., 1020 So. 40th Avenue, Suite A, Yakima, WA 98902								
16	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.								
17	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) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 5 days			
18			(B) DUE TO, OR AS A CONSEQUENCE OF:			INTERVAL BETWEEN ONSET AND DEATH			
18			(C) DUE TO, OR AS A CONSEQUENCE OF:			INTERVAL BETWEEN ONSET AND DEATH			
19	51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE Organic Brain Syndrome					52. AUTOPSY? (Yes, No) No		53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No) No	
20	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					
21 ACC LOC	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				
22 QUERIES	61. REGISTRAR SIGNATURE X <i>[Signature]</i>						62. DATE RECEIVED (Mo., Day, Yr.) OCT 12 1989		