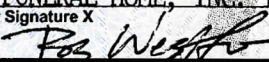


# STATE OF WASHINGTON DEPARTMENT OF HEALTH

Local File Number **747** **Washington State Certificate of Death** State File Number

1. Legal Name (include AKA's if any) First Middle LAST Suffix <b>HAROLD WARREN REDMAN</b>				2. Death Date <b>07-08-2010</b>	
3. Sex (M/F) <b>M</b>	4a. Age - Last Birthday <b>83</b>	4b. Under 1 Year Months Days	4c. Under 1 Day Hours Minutes	5. Social Security Number <b>519-20-6642</b>	6. County of Death <b>WHATCOM</b>
7. Birthdate <b>03-26-1927</b>		8a. Birthplace (City, Town, or County) <b>WATSEKA</b>		8b. (State or Foreign Country) <b>ILLINOIS</b>	
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify. <b>NO</b>			11. Decedent's Race(s) <b>WHITE</b>		12. Was Decedent ever in U.S. Armed Forces? <b>YES</b>
13a. Residence: Number and Street (e.g., 624 SE 5 <sup>th</sup> St.) (Include Apt. No.) <b>1450 VIEW VISTA PARK</b>				13b. City or Town <b>PORT ANGELES</b>	
13c. Residence: County <b>CLALLAM</b>		13d. Tribal Reservation Name (if applicable)		13e. State or Foreign Country <b>WA</b>	13f. Zip Code + 4 <b>98362</b>
14. Estimated length of time at residence. <b>9 YRS.</b>		15. Marital Status at Time of Death <b>WIDOWED</b>		16. Surviving Spouse's or Domestic Partner's Name (Give name prior to first marriage)	
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED). <b>TYPESETTER</b>				18. Kind of Business/Industry (Do not use Company Name) <b>NEWSPAPER</b>	
19. Father's Name (First, Middle, Last, Suffix) <b>JAMES REDMAN</b>			20. Mother's Name Before First Marriage (First, Middle, Last) <b>RUBY FELLOWS</b>		
21. Informant's Name <b>JODY HARROD</b>		22. Relationship to Decedent <b>DAUGHTER</b>		23. Mailing Address: Number and Street or RFD No. City or Town State Zip <b>709 9TH AVE. E., POLSON, MT 59860</b>	
24. Place of Death, if Death Occurred in a Hospital: <b>INPATIENT</b>				Place of Death, if Death Occurred Somewhere Other than a Hospital:	
25. Facility Name (If not a facility, give number & street or location) <b>ST. JOSEPH HOSPITAL</b>				26a. City, Town, or Location of Death <b>BELLINGHAM</b>	26b. State <b>WA</b>
27. Zip Code <b>98225</b>		28. Method of Disposition <b>CREMATION</b>		29. Place of Final Disposition (Name of cemetery, crematory, other place) <b>MT. VERNON CEMETERY CREMATORY</b>	
30. Location-City/Town, and State <b>MOUNT VERNON, WA</b>				31. Name and Complete Address of Funeral Facility <b>WESTFORD FUNERAL HOME, INC. 1301 BROADWAY, BELLINGHAM, WA 98225</b>	
32. Date of Disposition <b>07-08-2010</b>				3. Funeral Director Signature X  <b>ROB WESTFORD</b>	

Part 1 completed by Funeral Director

Part 2 completed by Certifier

**Cause of Death (See instructions and examples)**

34. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial infarction</b>	Interval between Onset & Death <b>3 weeks</b>
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST b. <b>Aortic stenosis</b>	Interval between Onset & Death <b>2 months</b>
c. <b>Atrial fibrillation</b>	Interval between Onset & Death <b>1 week</b>
d. <b>pulmonary HTN</b>	Interval between Onset & Death <b>2 months.</b>

35. Other significant conditions contributing to death but not resulting in the underlying cause given above  
**CLL (chronic lymphocytic leukemia)**

36. Autopsy?  Yes  No

37. Were autopsy findings available to complete the Cause of Death?  Yes  No

38. Manner of Death

<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Homicide	<input type="checkbox"/> Not pregnant within past year	<input type="checkbox"/> Not pregnant, but pregnant within 42 days before death
<input type="checkbox"/> Accident	<input type="checkbox"/> Undetermined	<input type="checkbox"/> Pregnant at time of death	<input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death
<input type="checkbox"/> Suicide	<input type="checkbox"/> Pending	<input type="checkbox"/> Unknown if pregnant within the past year	

39. If female

40. Did tobacco use contribute to death?  Yes  Probably  No  Unknown

41. Date of Injury (MM/DD/YYYY)

42. Hour of Injury (24hrs)

43. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)

44. Injury at Work?  Yes  No  Unk

45. Location of Injury: Number & Street: Apt No.

City or Town: County: State: Zip Code+ 4:

46. Describe how injury occurred

47. If transportation injury, specify:  
 Driver/Operator  Pedestrian  
 Passenger  Other (Specify)

48a. Certifying Physician - To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) and manner stated.  
**Thomas Oliver**

48b. Medical Examiner/Coroner - 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) and manner stated.

49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print)  
**DR. THOMAS OLIVER 2979 SQUALICUM PKWY, BELLINGHAM, WA 98225**

50. Hour of Death (24hrs)  
**0652**

51. Name and Title of Attending Physician if other than Certifier (Type or Print)

52. Date Signed (MM/DD/YYYY)  
**7/8/2010**

53. Title of Certifier  
**MD**

54. License Number

55. ME/Coroner File Number

56. Was case referred to ME/Coroner?  Yes  No

57. Registrar Signature  


58. Date Received (MM/DD/YYYY)  
**JUL 08 2010**

59. Amendments

