

When Recorded Please Return To:
LAWRENCE A. PIRKLE
321 W. Washington, Suite 300
Mount Vernon, WA 98273
(360) 336-6587



201202080038
Skagit County Auditor

2/8/2012 Page 1 of 3 12:08PM

DOCUMENT TITLE(S): WASHINGTON STATE CERTIFICATE OF DEATH

REFERENCE NUMBER(S): 200904130163

GRANTOR(S): HELEN MARGARET HUUS

GRANTEE(S): PUBLIC

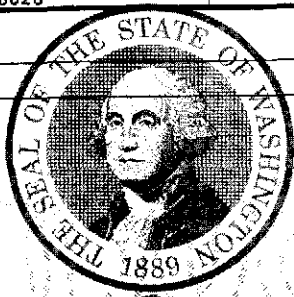
ABBREVIATED LEGAL DESCRIPTION: ISLAND VIEW PARK LOT 107

ASSESSOR PARCEL / TAX ID NUMBER: (P57642) 3798-000-107-0002

STATE OF WASHINGTON DEPARTMENT OF HEALTH

Local File Number **82-11** Washington State Certificate of Death State File Number

1. Legal Name (include AKA's if any) First Middle LAST Helen Margaret Huus			2. Death Date Feb 2, 2011		
3. Sex (M/F) F	4a. Age - Last Birthday 97	4b. Under 1 Year Months Days 0 0	4c. Under 1 Day Hours Minutes 0 0	5. Social Security Number [REDACTED]	6. County of Death Skagit
7. Birthdate [REDACTED]	8a. Birthplace (City, Town, or County) Northwood	8b. (State or Foreign Country) Iowa	9. Decedent's Education Doctorate		
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify. No			11. Decedent's Race(s) Caucasian		12. Was Decedent ever in U.S. Armed Forces? Yes
13a. Residence: Number and Street (e.g., 624 SE 5 th St.) (Include Apt. No.) 2212 - H Avenue				13b. City or Town Anacortes	
13c. Residence: County Skagit		13d. Tribal Reservation Name (if applicable)	13e. State or Foreign Country Washington	13f. Zip Code + 4 98221	13g. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
14. Estimated length of time at residence. 12 Years		15. Marital Status at Time of Death Never Married		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)) Professor			18. Kind of Business/Industry (Do not use Company Name) Universities		
19. Father's Name (First, Middle, Last, Suffix) Jacob Haaverson Huus			20. Mother's Name Before First Marriage (First, Middle, Last) Mary Belle [REDACTED]		
21. Informant's Name Jim Cartmell		22. Relationship to Decedent Nephew	23. Mailing Address: Number and Street or RFD No. City or Town State Zip 339 N 77th Street Seattle WA 98103		
24. Place of Death, if Death Occurred in a Hospital: Nursing Home			25. Facility Name (If not a facility, give number & street or location) San Juan Rehab & Care Center		
25. Facility Name (If not a facility, give number & street or location) San Juan Rehab & Care Center		26a. City, Town, or Location of Death Anacortes	26b. State WA	27. Zip Code 98221	
28. Method of Disposition Cremation		29. Place of Final Disposition (Name of cemetery, crematory, other place) Northwest Crematory		30. Location-City/Town, and State Anacortes, Washington	
31. Name and Complete Address of Funeral Facility Evans Funeral Chapel & Crematory, Inc. 1105 32nd Street Anacortes Washington 98221				32. Date of Disposition February 4, 2011	
33. Funeral Director Signature X <i>Jennie Helton</i>					
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. Interval between Onset & Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CANCER			Due to (or as a consequence of):		Interval between Onset & Death 6 mos
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.			Due to (or as a consequence of):		Interval between Onset & Death
c.			Due to (or as a consequence of):		Interval between Onset & Death
d.			Due to (or as a consequence of):		Interval between Onset & Death
35. Other significant conditions contributing to death but not resulting in the underlying cause given above:			36. Autopsy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		37. Were autopsy findings available to complete the Cause of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
38. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending		39. If female <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days before death <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"/> Unknown if pregnant within the past year		40. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> 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. Location of Injury: Number & Street: Apt No. [REDACTED]			45. City or Town: County: State: Zip Code + 4: [REDACTED]		
46. Describe how injury occurred			47. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> 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. Oliver L Stalsbroten M.D.			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) Oliver L. Stalsbroten, M.D 2511 M Avenue, Suite B Anacortes, WA 98221				50. Hour of Death (24hrs) 0915	
51. Name and Title of Attending Physician if other than Certifier (Type or Print)				52. Date Signed (MM/DD/YYYY) Feb 2, 2011	
53. Title of Certifier Dr.		54. License Number MD00018028		55. ME/Coroner File Number	
57. Registrar Signature <i>Mark Marshall, Deputy</i>			58. Date Received (MM/DD/YYYY) FEB 3 2011		
59. Amendments					



201202080038
Skagit County Auditor

STATE OF WASHINGTON
Department of Health

Form for Health Statistics
FD-100 (Rev. 10/10)
Replaces FD-997 (1984)
460106-000

This certificate is to be filled out by the person who has the best knowledge of the facts.

1. Name of the person whose name is being changed: _____
2. Date of birth: _____
3. Sex: _____
4. Race: _____
5. Date of death: _____
6. Affidavit Number: _____

7. Place of birth: _____
8. Place of death: _____

9. Name of the person who is making the change: _____
10. Relationship to the person whose name is being changed: _____
11. Address of the person making the change: _____
12. Telephone number: _____

13. I declare that the foregoing is true and correct.
14. Signature: _____
15. Title: _____

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95. Signature: _____
96. Title: _____



CERTIFIED
FEB 04 2011
Howard Leibrand
Skagit County Public Health Department
Howard Leibrand M.D., Health Officer

UU00007554

DOH - CHS 623a 6/11/10