

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH**

CERTIFIED COPY OF DEATH CERTIFICATE

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|--|---|---|---|---|
| File Number 3657 | | Washington State Certificate of Death | | State File Number |
| 1. Legal Name (include AKA's if any): First Middle LAST EARL C CLAYTON SR. | | | 2. Death Date April 14, 2004 | |
| 3. Sex (M/F) Male | 4a. Age - Last Birthday 75 | 4b. Under 1 Year Months Days | 4c. Under 1 Day Hours Minutes | 5. Social Security Number |
| 7. Birthdate Nov. 1, 1928 | | 8a. Birthplace (City, Town or County) Roxboro | 8b. (State or Foreign Country) North Carolina | 9. Decedent's Education High School Graduate |
| 10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify No | | | 11. Decedent's Race(s) White | |
| 13a. Residence: Number and Street (e.g., 824 SE 5 th St.) (Include Apt. No.) 23825 15th Ave. S.E. #311 | | | 13b. City or Town Bothell | |
| 13c. Residence: County King | | 13d. Tribal Reservation Name (if applicable) | 13e. State or Foreign Country Washington | 13f. Zip Code + 4 98021 |
| 14. Estimated length of time at residence 11 yrs. | | 15. Marital Status at Time of Death Married | 16. Surviving Spouse's Name (Give name prior to first marriage) Margaret Delaine Myers | |
| 17. Usual Occupation (Indicate type of work done during most of working life (DO NOT USE RETIRED)) QA Inspector | | | 18. Kind of Business/Industry (Do not use Company Name) Aerospace Industry | |
| 19. Father's Name (First, Middle, Last, Suffix) Archie C. Clayton | | | 20. Mother's Name Before First Marriage (First, Middle, Last) Lena M. Clayton | |
| 21. Informant's Name Margaret Clayton | | 22. Relationship to Decedent Wife | 23. Mailing Address: Number and Street or RFD No. City or Town State Zip 23825 15th Ave. S.E. #311 Bothell, WA 98021 | |
| 24. Place of Death, if Death Occurred in a Hospital: Hospice | | | 24. Place of Death, if Death Occurred Somewhere Other than a Hospital | |
| 25. Facility Name (if not a facility, give number & street or location) Evergreen Hospice | | | 26a. City, Town, or Location of Death Kirkland | 26b. State WA |
| 27. Zip Code 98034 | | 28. Method of Disposition Burial | | |
| 29. Place of Final Disposition (Name of cemetery, crematory, other place) Floral Hills Cemetery | | | 30. Location-City/Town, and State Lynnwood, Washington | |
| 31. Name and Complete Address of Funeral Facility Purdy & Walters @ Floral Hills 409 Filbert RD Lynnwood, WA 98036 | | | 32. Date of Disposition April 16, 2004 | |
| 33. Funeral Director Signature X <i>Greg Carlson</i> | | | | |
| 34. Enter the <u>chain of events</u> - 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. EMPHYSEMA | Due to (or as a consequence of): | Interval between Onset & Death |
| 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 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input 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. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| 45. Location of Injury: Number & Street City or Town County State Zip Code + 4 | | | 47. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify) | |
| 46. Describe how injury occurred | | | 48a. Certifying Physician: X <i>Michael D. Culberg MD</i> | |
| 49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print) Dr. Michael Eulberg 12911 120th Ave NE G-105 Kirkland, WA 98034 | | | 48b. Medical Examiner/Coroner: X | |
| 51. Name and Title of Attending Physician (if other than Certifier) (Type or Print) | | | 50. Hour of Death (24hrs) 0035 | 52. Date Signed (MM/DD/YYYY) 4/14/04 |
| 53. Title of Certifier M.D. | 54. License Number WA # 21703 | 55. ME/Coroner File Number | 56. Was case referred to ME/Coroner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 57. Registrar Signature X <i>Ashai Turner</i> | | | 58. Date Received (MM/DD/YYYY) APR 16 2004 | |
| 59. Amendments | | | | |

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DOH/CHS 003 Rev 2/06/2004
DOH-01-003 (5/99)