

1. NAME—FIRST, MIDDLE, LAST Beverly Ann McHONE			2. SEX Female		3. DEATH DATE (Mo., Day, Yr.) Jan. 30, 1990		146					
4. AGE LAST BIRTH-DAY (Yrs) 44		5. UNDER 1 YEAR MOS. DAYS HOURS MINS.		7. BIRTHDATE (Mo., Day, Yr.) May 15, 1945		8. BIRTH STATE (if not in USA give country) Washington		9. CITIZEN OF WHAT COUNTRY? USA		10. COUNTY OF DEATH Grays Harbor		
11. CITY, TOWN OR LOCATION OF DEATH Hoquiam				12. PLACE OF DEATH — <input checked="" type="checkbox"/> HOME <input type="checkbox"/> IN TRANSPORT <input type="checkbox"/> EMERG. RM/OUT PTN <input type="checkbox"/> HOSP. <input type="checkbox"/> NUR. HOME <input type="checkbox"/> OTHER PLACE 920 Smith Street						13. SMOKING IN LAST 15 YEARS? (Yes/No) Yes		
14. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) Divorced			15. SURVIVING SPOUSE (if wife, give maiden name) Daniel McHone			16. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes/No) NO		17. SOCIAL SECURITY NO. 532-38-3061		18. HIGH SCHOOL GRADUATE? (Yes/No) Yes		
19. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED) Mill Planer			20. KIND OF BUSINESS OR INDUSTRY Lumber Company			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, etc.) (Specify) White			
23. RESIDENCE - NUMBER AND STREET 920 Smith Street			24. CITY/TOWN, OR LOCATION Hoquiam		25. INSIDE CITY LIMITS? (Yes/No) Yes		26. COUNTY Grays Harbor		27. STATE Washington		28. ZIP CODE 98550	
29. FATHER'S NAME—FIRST, MIDDLE, LAST John Howey						30. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME Louise Alberthal						
31. INFORMANT—NAME Louise Edwards				32. MAILING ADDRESS STREET OR RFD NO. CITY OR TOWN STATE ZIP 920 Smith Street Hoquiam WA 98550								
33. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Cremation		34. DATE (Mo., Day, Yr.) 2-1-90		35. CEMETERY/CREMATORY—NAME Aberdeen Crematory			36. LOCATION—CITY/TOWN, STATE Aberdeen, Washington					
37. FUNERAL DIRECTOR SIGNATURE <i>Therence D. Pittack</i>		38. NAME OF FACILITY Coleman Mortuary, Inc.			39. ADDRESS OF FACILITY 422 - 5th St. Hoquiam, Washington 98550							
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 SIGNATURE AND TITLE <i>H.M. Johnson, Jr. DO</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 SIGNATURE AND TITLE X						
42. DATE SIGNED (Mo., Day, Yr.) 1-31-1990			43. HOUR OF DEATH (24 Hrs) 2340			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 (24 Hrs)			
49. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) H.M. Johnson, Jr., DO 400 - 8th Street Hoquiam, Washington 98550												
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) Pulmonary arrest			DUE TO, OR AS A CONSEQUENCE OF:			INTERVAL BETWEEN ONSET AND DEATH						
(B) Pulmonary metastatic malignancy			DUE TO, OR AS A CONSEQUENCE OF:			INTERVAL BETWEEN ONSET AND DEATH						
(C) Squamous cell carcinoma of cervix			DUE TO, OR AS A CONSEQUENCE OF:			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) No		53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes/No) NO		
54. ACC. SUICIDE HO., UNDET., OR PENDING INVEST. (Specify) No		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, BLOC., ETC. (Specify)				60. LOCATION—STREET OR RFD NO., CITY/TOWN, STATE						
61. REGISTRAR SIGNATURE X Robert C Sergeant								DEPUTY REGISTRAR		62. DATE RECEIVED (Mo., Day, Yr.) JAN 31 1990		

DECEDENT

PARENTS

DISPOSITION

CERTIFIER

CAUSE OF DEATH

DISTRICT -1
COPIES 2
HOSPITAL
RESIDENCE
OCCUPATION