

PROVINCE OF  
BRITISH COLUMBIA (Canada)  
DEPARTMENT OF HEALTH  
Division of Vital Statistics

REGISTRATION OF  
**DEATH**

Registration No.  
(Department use only)

007101

3 cents

NAME OF DECEASED	1. Surname of deceased (print or type) <del>Robson</del> <del>Gordon</del>		2. SEX XXXX Male
	All given names in full (print or type) Gordon Leonard		
PLACE OF DEATH	3. Name of hospital or institution (otherwise give exact location where death occurred) Ponderosa Lodge, 425 Columbia Street 4-000		Inside municipal limits? (State Yes or No) <b>yes</b>
	City, town or other place (by name) KAMLOOPS, B.C. 33042 V2C 2T4		
USUAL RESIDENCE	4. Complete street address: If rural give exact location (not Post Office or Rural Route address) 425 Columbia St.		Province (or country) B.C.
	City, town or other place (by name) KAMLOOPS, B.C. 33042 V2C 2T4		
MARITAL STATUS	5. Single, married, widowed, or divorced (Specify) Widower 3	6. If married, widowed, or divorced, give full name of husband or full maiden name of wife MARION Gilley	
OCCUPATION	7. Kind of work done during most of working life <del>XXXXXX</del> Carpenter	8. Kind of business or industry in which worked Construction	
BIRTHDATE	9. Month (by name), day, year of birth DEC. 10 / 1911	10. AGE (years) 574	(Months) (Days) (Hours) (Minutes) If under 1 year If under 1 day
BIRTHPLACE	11. City or place Province (or country) of birth NEW WESTMINSTER, B.C.		12. Native Indian? Yes No If "yes" state name of band <input type="checkbox"/> <input checked="" type="checkbox"/>
	13. Surname and given names of father (print or type) <del>XXXXXX</del> ROBSON, Leonard		
FATHER	14. BIRTHPLACE - City or place, Province (or country) N/K		999
MOTHER	15. Maiden surname and given names of mother (print or type) AMONSON N/K		16. BIRTHPLACE - City or place, Province (or country) N/K 999
INFORMANT	17. Signature of informant X <i>[Signature]</i>		18. Relationship to deceased Son
	19. Address of informant Box 1135, Kamloops, B. C. V2C 6H2		
DISPOSITION	21. Burial, cremation or other disposition (specify) Cremation 2		22. Date of burial or disposition (month, day, year) May 7, 1986
	23. Name and address of cemetery, crematorium or place of disposition Pine Grove Crematorium, Kamloops, B.C.		
FUNERAL DIRECTOR	24. Name and address of funeral director (or person in charge of remains) (print or type) Schoening Funeral Service, 513 Seymour Street, Kamloops, B. C.		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH	25. Month (by name), day, year of death MAY 6 1986		Approx. interval between onset & death
CAUSE OF DEATH	26. Part I Immediate cause of death (a) <i>Cancer Lung Oct. cell type</i> due to, or as a consequence of <i>metastasis</i>		
	Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last (b) _____ (c) _____		
	Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above <i>Emphysema</i> <i>Alcohol Liver disease</i>		20yr 20yr
AUTOPSY PARTICULARS	27. Autopsy being held? Yes No <input type="checkbox"/> <input checked="" type="checkbox"/>	28. Does the cause of death stated above take account of autopsy findings? Yes No <input type="checkbox"/> <input checked="" type="checkbox"/>	29. May further information relating to the cause of death be available later? Yes No <input type="checkbox"/> <input checked="" type="checkbox"/>
ACCIDENT OR VIOLENCE (If applicable)	30. If accident, suicide, homicide or undetermined (specify)	31. Place of injury (e.g. home, farm, highway, etc.)	32. Date of injury (Month (by name), day, year)
	33. How did injury occur? (describe circumstances)		
SURGICAL OPERATION	34. If there was a recent surgical operation give date of operation	35. State operative findings	
CERTIFICATION (attending physician, coroner, etc.)	36. I certify that to the best of my knowledge and belief the above-named person died on the date and from the causes stated herein: Signature (attending physician, coroner, etc.) X <i>[Signature]</i> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
	37. Name of physician or coroner (print or type) <i>DR. [Signature]</i>	Address <i>[Address]</i>	Date: Month, day, year <i>05 06 80</i>

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Notations:

CERTIFICATION OF DISTRICT REGISTRAR	I certify this return was accepted by me on this date at - KAMLOOPS B.C.	
	District Registration No. 170	Date: Month (by name), day, year MAY 7, 1986. <i>[Signature]</i>

See Reverse for Instructions  
IMPORTANT: Any change or correction made in the completion of this form must be initialed by the person certifying the original information.