



201611020008

Skagit County Auditor

\$75.00

11/2/2016 Page

1 of

3 10:53AM

When recorded return to:

## QUIT CLAIM DEED

THE GRANTOR(S) JOSEPH FUCHS

for and in consideration of \$23,250.00

in hand paid, conveys and quit claims to DAVID A. LOFTON  
and  
CHERY C. LOFTON

the following described real estate, situated in the County of SKAGIT, State of Washington

together with all after acquired title of the grantor(s) herein:

Auditor's Parcel # 104846

LOT 12 OF LONE STAR'S ADDITION TO CONCRETE,  
SEC 10, T35N, R8E.STREET ADDRESS: 330 LIMESTONE STREET  
CONCRETE, WA 98237

Abbreviated Legal: (Required if full legal not inserted above)

Tax Parcel Number(s):

# P 104846

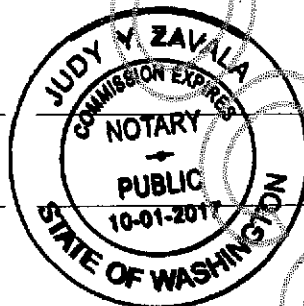
SKAGIT COUNTY WASHINGTON  
REAL ESTATE EXCISE TAX  
2016 5006  
NOV 02 2016

Dated:

NOVEMBER 2, 2016

Amount Paid \$418.85  
Skagit Co. Treasurer  
By [Signature] Deputy

Joseph Fuchs



STATE OF WA

COUNTY OF Skagit

ss.

I certify that I know or have satisfactory evidence that

Joseph Fuchs

(is/are) the person(s) who appeared

before me, and said person(s) acknowledged that he signed this instrument and acknowledged it to be  
free and voluntary act for the uses and purposes mentioned in this instrument.

Dated:

November 2, 2016

Notary name printed or typed:

Notary Public in and for the State of

Residing at

My appointment expires:

Judy Y. Zavala  
Burlington  
10-1-2017

# STATE OF WASHINGTON DEPARTMENT OF HEALTH

Local File Number <b>442</b>		<b>Washington State Certificate of Death</b>				State File Number	
1. Legal Name (include AKA's if any) First Middle LAST <b>Lucrezia (None) Fuchs</b>					2. Death Date <b>04/07/2011</b>		
3. Sex (M/F) <b>Female</b>	4a. Age - Last Birthday <b>77</b>	4b. Under 1 Year Months Days <b>0 0</b>	4c. Under 1 Day Hours Minutes <b>0 0</b>	5. Social Security Number <b>[REDACTED]</b>	6. County of Death <b>Whatcom</b>		
7. Birthdate <b>[REDACTED]</b>	8a. Birthplace (City, Town, or County) <b>Cunier</b>	8b. (State or Foreign Country) <b>Switzerland</b>		9. Decedent's Education <b>Bachelors Degree</b>			
10. Was Decedent of Hispanic Origin? (Yes or No) If yes, specify. <b>No</b>				11. Decedent's Race(s) <b>Caucasian</b>		12. Was Decedent ever in U.S. Armed Forces? <b>No</b>	
13a. Residence: Number and Street (e.g., 824 SE 5th St.) (Include Apt. No.) <b>2904 Cherrywood Avenue</b>					13b. City or Town <b>Bellingham</b>		
13c. Residence: County <b>Whatcom</b>		13d. Tribal Reservation Name (if applicable)		13e. State or Foreign Country <b>Washington</b>	13f. Zip Code + 4 <b>98225</b>	13g. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
14. Estimated length of time at residence. <b>2 Years</b>		15. Marital Status at Time of Death <b>Married</b>		16. Surviving Spouse's or Domestic Partner's Name (Give name prior to first marriage) <b>Joseph L. Fuchs</b>			
17. Usual Occupation (Indicate type of work done during most of working life. (DO NOT USE RETIRED).) <b>Bookkeeper</b>				18. Kind of Business/Industry (Do not use Company Name) <b>Wholesale</b>			
19. Father's Name (First, Middle, Last, Suffix) <b>Carla Cola</b>				20. Mother's Name Before First Marriage (First, Middle, Last) <b>Maria-Ursula [REDACTED]</b>			
21. Informant's Name <b>Joseph Fuchs</b>		22. Relationship to Decedent <b>Husband</b>		23. Mailing Address: Number and Street or RFD No. City or Town State Zip <b>2904 Cherrywood Ave. Bellingham WA 98225</b>			
24. Place of Death, if Death Occurred in a Hospital: <b>Decedent's Home</b>				25. Facility Name (If not a facility, give number & street or location) <b>2904 Cherrywood Avenue</b>			
26. Method of Disposition <b>Cremation</b>		29. Place of Final Disposition (Name of cemetery, crematory, other place) <b>Moles Greenacres Crematory</b>		30. Location-City/Town, and State <b>Ferndale, Washington</b>		32. Date of Disposition <b>April 12, 2011</b>	
31. Name and Complete Address of Funeral Facility <b>Moles Ferndale 2039 Main St. Ferndale, WA 98248</b>				33. Funeral Director's Signature <b>Steve Horteegas</b>			
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) → <b>Malignant neoplasm of ovary</b> <span style="float: right;">Interval between Onset &amp; Death <b>Years</b></span>							
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>Heart</b> <span style="float: right;">Interval between Onset &amp; Death</span>							
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 checked="" 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. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
45. Location of Injury: Number & Street: <b>[REDACTED]</b>				46. Describe how injury occurred <b>[REDACTED]</b>			
47. If transportation injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)				48. 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. <b>[REDACTED]</b>			
49. Name and Address of Certifier - Physician, Medical Examiner or Coroner (Type or Print) <b>Hannah Buja, MD 1610 Grover St Lynden, WA 98264</b>				50. Hour of Death (24hrs) <b>0600</b>			
51. Name and Title of Attending Physician if other than Certifier (Type or Print) <b>John Hiemstra, MD</b>				52. Date Signed (MM/DD/YYYY) <b>04/07/2011</b>			
53. Title of Certifier <b>M.D.</b>		54. License Number <b>6017843</b>		55. ME/Coroner File Number		56. Was case referred to ME/Coroner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
57. Registrar Signature <b>Greg [REDACTED]</b>				58. Date Received (MM/DD/YYYY) <b>April 12, 2011</b>			
59. Amendments #20 FH Aff 4/26/11 ah							



DOH/CHS 003 Rev. 07/03/07

DOH 01-003 (6/10)

# Birth Affidavit

Department of Health Statistics  
201 West 7th St.  
Cheyenne, WY 82001-1700  
Phone: 337-236-3300

Do not write in the spaces provided. Do not alter or change the information in this form. Do not use this form for any other purpose.

1. Name of Person: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_\_ 3. Sex: \_\_\_\_\_ 4. Affidavit Number: \_\_\_\_\_

5. Name of Mother: \_\_\_\_\_ 6. Name of Father: \_\_\_\_\_ 7. Name of Informant: \_\_\_\_\_

8. Date of Event: \_\_\_\_\_ 9. Place of Event: (City or County) \_\_\_\_\_

10. Name of Informant: \_\_\_\_\_ 11. Telephone Number: \_\_\_\_\_

12. I represent the person(s) \_\_\_\_\_

13. I declare under penalty of perjury that the foregoing is true and correct.

14. Signature of \_\_\_\_\_

15. Signature of \_\_\_\_\_

16. Signature of \_\_\_\_\_

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**\*CERTIFIED\***

APR 26 2011

Greg Stern  
Whatcom County Health Department  
Greg Stern M.D., Health Officer

UU00017308