

**Return Address:**

**Joseph D. Bowen, Attorney at Law P.S.**  
401 S. 2<sup>nd</sup> Street  
Mount Vernon, WA



**201808300059**

08/30/2018 01:30 PM Pages: 1 of 3 Fees: \$101.00  
Skagit County Auditor

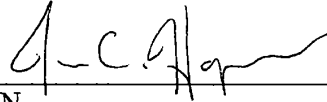
State of OREGON )  
:SS  
County of JACKSON)

**LACK OF PROBATE AFFIDAVIT**

JANA HOGAN, Affiant, being by me first duly sworn upon his/her oath, did depose and say under penalty of perjury:

1. This affidavit is made pursuant to RCW 82.45.197.
2. The full name of the decedent is: RICHARD ALBERT MILLER.
3. The decedent died on **9/16/15** at MEDFORD, JACKSON COUNTY, OREGON.
4. My relationship to the decedent is as follows: SURVIVING SPOUSE.
5. I am the rightful heir to the property described herein.
6. Decedent left a Will that is not being probated.
7. The property subject to this affidavit is described as: LOT 20, BLOCK 4, THUNDERBIRD LANE, AS PER PLAT RECORDED IN VOLUME 8 OF PLATS, PAGES 76 AND 77, RECORDS OF SKAGIT COUNTY, WASHINGTON. Tax ID Number: **P70086**
8. A certified copy of the deceased's Death Certificate is attached.

9. The deceased is survived by the following heir(s): JANA C. HOGAN, his spouse.



JANA C. HOGAN  
776 Holcomb Springs Road  
Gold Hill, OR 97524

State of Oregon

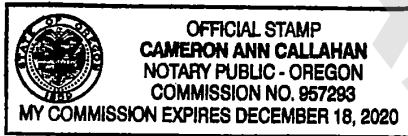
County of: Jackson

I certify that I know or have satisfactory evidence that JANA C. HOGAN is the person who appeared before me, and said person acknowledged that she signed this instrument and acknowledged it to be her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: 08/28/2018



Signature



NOTARY PUBLIC FOR Oregon

My appointment expires: 12/18/2020

# STATE OF OREGON

## CERTIFICATION OF VITAL RECORD

### OREGON HEALTH AUTHORITY CENTER FOR HEALTH STATISTICS CERTIFICATE OF DEATH

708676  
I.D. TAG NO.

STATE FILE NUMBER

1. Legal Name First: Richard Middle: A Last: Miller Suffix:			2. Death Date September 16, 2015	
3. Sex Male	4. Age 68 years	5. Social Security Number		6. County of Death Jackson
7. Birthdate	8. Birthplace Pensacola, Florida		9. Decedent's Education Master's degree	
10. Was Decedent of Hispanic Origin? No			11. Decedent's Race(s) White	
12. Was Decedent Ever in U.S. Armed Forces? No				
13. Residence: Number and Street 776 Holcomb Spings Road			14. City/Town Gold Hill	
15. Residence County Jackson		16. State or Foreign Country Oregon		17. Zip Code + 4 97525
18. Marital Status at Time of Death Married			19. Spouse's Name Prior to First Marriage Jana Hogan	
20. Usual Occupation Owner/Operator			21. Kind of Business/Industry Hospitality	
22. Father's Name Albert Miller			23. Mother's Name Prior to First Marriage Elizabeth	
24. Informant's Name Jana Hogan			25. Telephone Number Not Available	
26. Relationship to Decedent Spouse			27. Mailing Address 776 Holcomb Springs Road, Gold Hill, OR 97525	
28. Place of Death Hospital-Emergency Room/Outpatient			29. Facility Name Providence Medford Medical Center	
30. Location of Death 1111 Crater Lake Avenue			31. City/Town or Location of Death Medford	
32. State Oregon			33. Zip Code + 4 97504	
34. Method of Disposition Cremation			35. Place of Disposition Siskiyou Memorial Park	
36. Name and Complete Address of Funeral Facility Peri Funeral Home 2100 Siskiyou Blvd, Medford, Oregon 97504				
37. Date of Disposition September 21, 2015			38. Funeral Director's Signature Bret Benzley	
39. Registrar's Signature Madeline Bell			40. Date Received SEP 23 2015	
41. OR License Number CO-3841			42. Local File Number	
43. Amendment				
44. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
45. Autopsy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
46. Were autopsy findings available to complete the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
47. Time of Death 5:02 PM				
48. CAUSE OF DEATH				
49. 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.				Approximate Interval: Onset to Death
Final disease or condition resulting in death -> IMMEDIATE CAUSE a. <u>Coronary Fibrillation</u>				~ 1 hr
Due to (or as a consequence of) b. <u>Severe Aortic Myocardial Infarction</u>				~ 1 hr
Due to (or as a consequence of) c. <u>Arteriosclerotic Vascular Disease</u>				> 10 yrs
Due to (or as a consequence of) d. <u>Hypertensive Intracerebral Vascular</u>				> 20 yrs
50. Other significant conditions contributing to death, but not resulting in the underlying cause given above: N/A				
51. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Poisoning				
52. If Female: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown (if pregnant within the past year)				
53. Did tobacco use contribute to death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
54. Date of Injury N/A		55. Time of Injury		56. Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area)
57. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
58. Location of Injury (Number & Street of RFD No., City/Town, State, Zip + 4)				
59. Describe how Injury occurred				
60. If transportation Injury, specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)				
61. Name and Address of Certifier (Number & Street of RFD No., City/Town, State, Zip + 4) Dr. John Delgado, 148 E. Hersey St., Ashland OR 97520				
62. Name and Title of Attending Physician (if Other than Certifier)				
63. Title of Certifier Medical Doctor		64. License Number M10 16862		65. Date Signed SEP 23 2015
66. Medical Certifier - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				
67. Medical Examiner - 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.				
68. Amendment				

\*4513929\*

TO BE COMPLETED BY MEDICAL CERTIFIER

9/16 9-23-15

45-2DP (01/06)

I CERTIFY THAT THIS IS A TRUE, FULL AND CORRECT COPY OF THE ORIGINAL CERTIFICATE ON FILE OR THE VITAL RECORD FACTS ON FILE IN THE OREGON CENTER FOR HEALTH STATISTICS OR A DELEGATED LOCAL OFFICE.

SEP 23 2015

DATE ISSUED:

JENNIFER A. WOODWARD, Ph.D.  
STATE REGISTRAR

THIS COPY IS NOT VALID WITHOUT INTAGLIO STATE SEAL AND BORDER.

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

