FILED FOR RECORD AT REQUEST OF

Joseph A. Sowers, Trustee
The Barker Family Revocable Living Trust
18801 86th Place West
Edmonds, Washington 98026-5907

87-1436
DELAWARE COUNTY IOWA
FILED
'94 NOV 30 AM 10 37
BOOK 18 PAGE 64
DEBORAH L. PEYTON
DELAWARE CO. RECORDER
$11.00

TRUSTEE'S AFFIDAVIT

STATE OF WASHINGTON)
) **ss**
COUNTY OF SNOHOMISH)

THE UNDERSIGNED, being first duly sworn, deposes and says:

1. This Affidavit is made with respect to the real property in the State of Iowa owned by The Barker Family Revocable Living Trust, dated October 20, 1993 and more particularly described as:

   The NW 1/4 of Sec. 5 Twp. 87 North, Range 6, W of 5th P.M.,

   and

   E 1/2 of SW 1/4 and N 25 acres of the W 1/2 of SW 1/4 except railroad right-of-way all in Sec. 7, Twp. 87, Range 6, W of the 5th P.M.

2. The Trustor, Ethel M. Barker died on December 4, 1993 as evidenced by the attached death certificate.

3. The Affiant, Joseph A. Sowers, is the sole Trustee of said trust, and is distributing the above described assets of the trust to the trust beneficiaries in accordance with the trust directions.

4. **FURTHER AFFIANT SAYETH NAUGHT.**

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 29th day of November, 1994

SWORN TO AND SUBSCRIBED

Joseph A. Sowers
AFFIANT JOSEPH A. SOWERS

On this day before me, a Notary Public in and for the State of Washington, personally appeared Joseph A. Sowers to me known to be the person who executed the foregoing instrument, in behalf of The Barker Family Revocable Living Trust, and acknowledged that that person executed the same as the voluntary act and deed, of said trust.

WITNESS my hand and offical seal this 29th day of November, 1994

NANCY RUTH CRAWFORD
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
AUG. 20, 1995

Nancy Ruth Crawford
Notary Public in and for the State of Washington
Residing at Edmonds
Nancy Ruth Crawford
My commission expires: Aug. 20, 1995

FILE No. 87-1436	FILED FOR RECORD THE 30 DAY OF Nov 1994 AT 10:37	STATE OF IOWA, DELAWARE COUNTY
RECORDING FEE $ 11.00	O'CLOCK A. M. BOOK 18 PAGE 64	Deborah L. Peyton, Recorder
TRANSFER FEE $		AFF.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

TYPE OR PRINT IN PERMANENT BLACK INK

0591
LOCAL FILE NUMBER

Washington State Department of Health

CERTIFICATE OF DEATH

146
STATE FILE NUMBER

DECEDENT

1. NAME First	Middle	Last	2. SEX (M / F)	3. DEATH DATE (Mo, Day, Yr)
ETHEL	MAE	BARKER	Female	December 4, 1993

4. AGE LAST BIRTHDAY (Yrs)	5. UNDER 1 YEAR MOS / DAYS	6. UNDER 1 DAY HOURS / MINS	7. BIRTHDATE (Mo, Day, Yr)	8. BIRTHPLACE (City, State or Foreign Country)	9. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes / No)	10. COUNTY OF DEATH
87			Apr 21, 1906	Manchester, IA	No	Clallam

11. CITY, TOWN OR LOCATION OF DEATH	12. PLACE OF DEATH—☒ BOX FOR PLACE THEN GIVE ADDRESS OR INSTITUTION NAME 1 ☐ HOME 2 ☐ IN TRANSPORT 3 ☐ EMERG RM/OUT PTN 4 ☐ HOSP. 5 ☒ NUR HOME 6 ☐ OTHER PLACE	13. SMOKING IN LAST 15 YEARS? (Yes / No)
Sequim	Olympic Health Care Center	No

14. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	15. SURVIVING SPOUSE (If wife, give maiden name)	16. SOCIAL SECURITY NO	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
			Elementary/Secondary (0-12)	College (1-4 or 5+)
Widowed	n/a	[redacted]		4+

18. USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT USE RETIRED)	19. KIND OF BUSINESS OR INDUSTRY	20. Was Decedent of Hispanic origin or descent? (Ancestry) (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) (Yes / No) Specify	21. RACE (Specify)
Home Maker	own Home	No	White

22. RESIDENCE—NUMBER AND STREET	23. CITY/TOWN, OR LOCATION	24. INSIDE CITY LIMITS? (Yes / No)	25A. COUNTY	25B. LENGTH OF RES. IN CO.	26. STATE	27. ZIP CODE
150 Sunland Dr.	Sequim	No	Clallam	55 Yrs	WA	98382

PARENTS

28. FATHER'S NAME—FIRST, MIDDLE, LAST	29. MOTHER'S NAME—FIRST, MIDDLE, MAIDEN SURNAME
Thomas A. McRoberts	Mary Robinson

30. INFORMANT—NAME	31. MAILING ADDRESS STREET OR RFD NO.	CITY OR TOWN	STATE	ZIP
Sandra Sowers	18801 86th Place West,	Edmonds, WA		98026

DISPOSITION

32. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	33. DATE (Mo, Day, Yr)	34. CEMETERY/CREMATORY—NAME	35. LOCATION—CITY/TOWN, STATE
Cremation	12/7/93	Mt. Angeles Crematory	Port Angeles, WA 98362

36. FUNERAL DIRECTOR SIGNATURE	37. NAME OF FACILITY	38. ADDRESS OF FACILITY
X1584 Larry P. Weil	Olympic Cremation Association	PO 340 Port Angeles, WA 98362

CERTIFIER

TO BE COMPLETED ONLY BY CERTIFYING PHYSICIAN	TO BE COMPLETED ONLY BY MEDICAL EXAMINER OR CORONER
39. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X Roger Olsen M.D.	43. ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION DEATH OCCURRED AT THE TIME, DATE AND PLACE AND WAS DUE TO THE CAUSE(S) STATED. SIGNATURE AND TITLE X
40. DATE SIGNED (Mo., Day, Yr) December 6, 1993	41. HOUR OF DEATH (24 Hrs.) 1815 hrs.
42. NAME AND TITLE OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)	44. DATE SIGNED (Mo., Day, Yr) / 45. HOUR OF DEATH (24 Hrs) / 46. PRONOUNCED DEAD (Mo., Day, Yr) / 47. HOUR PRONOUNCED DEAD (24 Hrs.)
48. NAME AND ADDRESS OF CERTIFIER—PHYSICIAN, MEDICAL EXAMINER OR CORONER (Type or Print) Roger Olsen, M.D. 933 N. 5th Sequim, WA 98382	49. ME/CORONER FILE NUMBER

CAUSE OF DEATH

50. ENTER THE DISEASES, INJURIES, OR COMPLICATIONS WHICH CAUSED THE DEATH:

IMMEDIATE CAUSE (Final disease or condition resulting in 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. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST.

		INTERVAL BETWEEN ONSET AND DEATH
A.	Cerebrovascular accident	1 week
DUE TO, OR AS A CONSEQUENCE OF: B.	Atherosclerotic Cerebrovascular Disease	10 yrs
DUE TO, OR AS A CONSEQUENCE OF: C.		
DUE TO, OR AS A CONSEQUENCE OF: D.		

51. OTHER SIGNIFICANT CONDITIONS—CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN ABOVE.	52. AUTOPSY? (Yes / No)	53. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? (Yes / No)
	NO	NO

54. ACC, SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)	55. INJURY DATE (Mo, Day, Yr)	56. HOUR OF INJURY (24 Hrs)	57. DESCRIBE HOW INJURY OCCURRED
n/a	n/a	n/a	n/a

58. INJURY AT WORK? (Yes / No)	59. PLACE OF INJURY—AT HOME, FARM, STREET, FACTORY, OFFICE BLDG, ETC. (Specify)	60. LOCATION—STREET OR RFD NO., CITY/TOWN, STATE
n/a	n/a	n/a

61. RECORD AMENDMENT (Registrar use only) ITEM / DOCUMENTARY EVIDENCE / REVIEWED BY / DATE	62. REGISTRAR SIGNATURE	63. DATE RECEIVED (Mo., Day, Yr.)
	X [signature] MD	DEC 07 1993

FOR INSTRUCTIONS SEE BACK AND HANDBOOK

DOH 110-008 (Rev 7/91) (formerly DSHS 9-150)
DOH 01-003 (5/92)

THIS IS A CERTIFIED COPY OF THE RECORD ON FILE WITH CENTER FOR HEALTH STATISTICS. CERTIFIED COPIES MUST HAVE THE OFFICIAL SEAL