STATE OF WASHINGTON
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

5420691

CERTIFICATE NUMBER: **2020-031411**

DATE ISSUED: **07/21/2020**
FEE NUMBER: **110789829**

FIRST AND MIDDLE NAME(S): **MARY KATHERINE**
LAST NAME(S): **FUALAAU**

COUNTY OF DEATH: **KING**
DATE OF DEATH: **JULY 06, 2020**
HOUR OF DEATH: **12:01 PM**
SEX: **FEMALE** AGE: **58 YEARS**
SOCIAL SECURITY NUMBER: [redacted]

HISPANIC ORIGIN: **NO, NOT SPANISH/HISPANIC/LATINO**
RACE: **WHITE**

BIRTH DATE: **JANUARY 30, 1962**
BIRTHPLACE: **CA**

MARITAL STATUS: **MARRIED**
SURVIVING SPOUSE: **VILI FUALAAU**

OCCUPATION: **EDUCATOR**
INDUSTRY: **EDUCATION**
EDUCATION: **MASTER'S DEGREE**
US ARMED FORCES: **NO**

INFORMANT: **VILI FUALAAU**
RELATIONSHIP: **SPOUSE**
ADDRESS: [redacted]

CAUSE OF DEATH:
A: **WIDELY METASTATIC COLORECTAL CANCER**
INTERVAL: **YEARS**
B:
INTERVAL:
C:
INTERVAL:
D:
INTERVAL:

OTHER CONDITIONS CONTRIBUTING TO DEATH:

DATE OF INJURY:
HOUR OF INJURY:
INJURY AT WORK:
PLACE OF INJURY:

LOCATION OF INJURY:

CITY, STATE, ZIP:
COUNTY:
DESCRIBE HOW INJURY occurred:

IF TRANSPORTATION INJURY, SPECIFY: **NOT APPLICABLE**

PLACE OF DEATH: **HOME**
FACILITY OR ADDRESS: [redacted]
CITY, STATE, ZIP: **DES MOINES, WASHINGTON 98198**

RESIDENCE STREET: [redacted]
CITY, STATE, ZIP: **DES MOINES, WA 98198**
INSIDE CITY LIMITS: **YES** COUNTY: **KING**
TRIBAL RESERVATION: **NOT APPLICABLE**
LENGTH OF TIME AT RESIDENCE: **3 YEARS**

FATHER: **JOHN SCHMITZ**
MOTHER: **MARY SUEHR**

METHOD OF DISPOSITION: **CREMATION**
PLACE OF DISPOSITION: **EVERGREEN WASHELLI CREMATORY**

CITY, STATE: **SEATTLE, WASHINGTON**
DISPOSITION DATE: **JULY 13, 2020**

FUNERAL FACILITY: **CASCADE MEMORIAL BELLEVUE**

ADDRESS: [redacted]
CITY, STATE, ZIP: **BELLEVUE, WASHINGTON 98005**
FUNERAL DIRECTOR: **ROBIN DITTMAN**

MANNER OF DEATH: **NATURAL**
AUTOPSY: **UNKNOWN**
WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE
CAUSE OF DEATH: **NOT APPLICABLE**
DID TOBACCO USE CONTRIBUTE TO DEATH: **UNKNOWN**
PREGNANCY STATUS IF FEMALE: **NO RESPONSE**

CERTIFIER NAME: **BRUCE C. SMITH, MD**
TITLE: **PHYSICIAN**
CERTIFIER ADDRESS: [redacted]
CITY, STATE, ZIP: **TUKWILA, WA 98168**
DATE SIGNED: **JULY 06, 2020**

CASE REFERRED TO ME/CORONER: **NO**
FILE NUMBER: **NOT APPLICABLE**
ATTENDING PHYSICIAN: **NOT APPLICABLE**

LOCAL DEPUTY REGISTRAR: **DIANE BOGAN**
DATE RECEIVED: **JULY 13, 2020**

DOH 422-132 King (8/18)

NOT VALID IF PHOTOCOPIED OR ALTERED