

**Affidavit-Termination of Joint Tenancy  
(Death of a Joint Tenant)**

ASSESSOR'S PARCEL NO. (APN#): 007-392-03

RECORDING REQUESTED BY AND MAIL TAX STATEMENT TO  
Name: Jana Rowe  
Address: PO Box 872  
City/State/Zip: Eureka, NV 89316

EUREKA COUNTY, NV  
LAND-TJT  
Rec:\$37.00  
Total:\$37.00  
JANA ROWE

**2024-251907**  
**04/01/2024 12:08 PM**  
Pgs=2



00019925202402519070020023  
KATHERINE J. BOWLING, CLERK RECORDER

I, Jana Rowe, the Affiant, being of legal age, and being first duly sworn,  
deposes and says:  
That Stephen Rowe (Deceased Name as shown on Death Certificate), the decedent mentioned in the

attached certified copy Certificate of Death, is the same person as Stephen Rowe (Deceased Name as shown on Deed)

named as one of the parties in that certain Grant, Bargain, Sale Deed (Type of Document)

dated on the 10<sup>th</sup> day of June, 2019, and executed by David Pastorino, known as "Grantor(s)" to Jana L Rowe and Stephen Rowe known as "Grantee(s)", as Joint Tenants, and recorded as Instrument No. 96029 on the 1<sup>st</sup> day of October, 1984, in book 96029 of Official Records of Eureka County, Nevada, covering the following described property situated in the City of Eureka, County of Eureka, State of Nevada.  
(Set forth legal description and commonly known street address, if known)

Lot 4 as shown on that certain Parcel Map for E and R INC. filed in the office of the County Recorder of Eureka County, State of Nevada, on October 1, 1984, as File No. 96029, being a portion of Parcel "G" of the Large Division Map of E1/2 Section 17, TOWNSHIP 20 NORTH, RANGE 53 EAST, M.D.B.&M.

EXCEPTING THEREFROM all the oil and gas lying in and under said land as reserved by the U.S.A., in Patent recorded April 15, 1966, in Book 10, Page 331, Official Records, Eureka County, Nevada.

That value of all real property owned by decedent at date of death, including the full value of the property above described, did not exceed the sum of \$ 60,000.00.

In witness Whereof, I/We have hereunto set my hand/our hands this 1<sup>st</sup> day of April, 2024

Jana L Rowe  
(Signature) \_\_\_\_\_  
Jana L Rowe  
(Print or type name here)

\_\_\_\_\_  
(Signature) \_\_\_\_\_  
\_\_\_\_\_  
(Print or type name here)

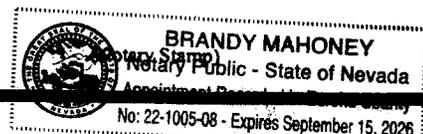
STATE OF NEVADA )

COUNTY OF EUREKA )

This instrument was acknowledged before me on (date) 04/01/2024

By (person(s) appearing before notary public) BRANDY MAHONEY

Br Mahoney  
(Notary Public)  
My Commission expires: SEPT 15, 2026



# STATE OF NEVADA

## CERTIFICATION OF VITAL RECORD

### DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF PUBLIC AND BEHAVIORAL HEALTH VITAL STATISTICS

CASE FILE NO. 3891870

### CERTIFICATE OF DEATH

2016008070  
STATE FILE NUMBER

|   |   |  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
|---|---|--|--|--|--|-------------------------------------|--|--|--|--|--|-----------------------|--|-----------------------------------|--|--|--|--|--|--------------------------------|--|--------------------------------|--|----------------------------------|--|-------------------------------|--|--|--|--|--|--|--|---|--|----------------------------|--|---|--|---|--|--|--|----------------------------|--|---|--|---|--|---|--|-----------------------------|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|---|--|------------------------------------|--|--|--|--|--|--|--|--|--|------------------------------|--|--------------------|--|--|--|----------------------------------|--|--------------------------------|--|--|--|--|--|--|--|------------------------------------|--|---|--|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|--|--|---|--|---------------------------------|--|--|--|----------------------------------|--|-------------------------------------|--|--|--|----------------------------------|--|-------------------------------------|--|--|--|----------------------------------|--|-----|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------|--|---------------------|--|-----------------------------------|--|--|--|--|--|---|--|---|--|---|--|
| TYPE OR PRINT IN PERMANENT BLACK INK<br><br>DECEDENT<br><br>IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS<br><br>PARENTS<br><br>DISPOSITION<br><br>TRADE CALL<br><br>CERTIFIER<br><br>REGISTRAR<br><br>CAUSE OF DEATH<br><br>CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">1a. DECEASED-NAME (FIRST,MIDDLE, LAST,SUFFIX)<br/><b>Stephen ROWE</b></td> <td colspan="2">2. DATE OF DEATH (Mo/Day/Year)<br/><b>May 01, 2016</b></td> <td colspan="2">3a. COUNTY OF DEATH<br/><b>Clark</b></td> </tr> <tr> <td colspan="2">3b. CITY, TOWN, OR LOCATION OF DEATH<br/><b>Las Vegas</b></td> <td colspan="2">3c. HOSPITAL OR OTHER INSTITUTION -Name(If not either, give street and Inpatient(Specify))<br/><b>6997 Pinebrook Court Home</b></td> <td colspan="2">4. SEX<br/><b>Male</b></td> </tr> <tr> <td colspan="2">5. 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No, City or Town, State, Zip)<br/><b>6997 Pinebrook Court Las Vegas, Nevada 89147</b></td> </tr> <tr> <td colspan="2">19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br/><b>Anatomical Donation/Cremation</b></td> <td colspan="2">19b. CEMETERY OR CREMATORY - NAME<br/><b>Paradise Valley Crematory</b></td> <td colspan="2">19c. LOCATION City or Town State<br/><b>Las Vegas Nevada 89119</b></td> </tr> <tr> <td colspan="2">20a. FUNERAL DIRECTOR - SIGNATURE (Of Person Acting as Such)<br/><b>ALLEN KOPP</b><br/>SIGNATURE AUTHENTICATED</td> <td colspan="2">20b. FUNERAL DIRECTOR OF LICENSE NUMBER<br/><b>772</b></td> <td colspan="2">20c. NAME AND ADDRESS OF FACILITY<br/><b>Davis Funeral Home and Memorial Park</b><br/><b>6200 S Eastern Las Vegas NV 89119</b></td> </tr> <tr> <td colspan="6">21. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature &amp; Title)<br/><b>CRAIG M JORGENSEN M.D.</b><br/>SIGNATURE AUTHENTICATED</td> </tr> <tr> <td colspan="2">21b. DATE SIGNED (Mo/Day/Yr)<br/><b>May 03, 2016</b></td> <td colspan="4">21c. HOUR OF DEATH<br/><b>20:23</b></td> </tr> <tr> <td colspan="6">22. 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) stated. (Signature &amp; Title)</td> </tr> <tr> <td colspan="2">22b. DATE SIGNED (Mo/Day/Yr)</td> <td colspan="4">22c. HOUR OF DEATH</td> </tr> <tr> <td colspan="2">22d. PRONOUNCED DEAD (Mo/Day/Yr)</td> <td colspan="4">22e. PRONOUNCED DEAD AT (Hour)</td> </tr> <tr> <td colspan="4">23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print)<br/><b>Craig M Jorgenson-M.D. 6330 S Jones Blvd Las Vegas, NV 89118</b></td> <td colspan="2">23b. LICENSE NUMBER<br/><b>9529</b></td> </tr> <tr> <td colspan="2">24a. 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| 3b. CITY, TOWN, OR LOCATION OF DEATH<br><b>Las Vegas</b>  |   | 3c. HOSPITAL OR OTHER INSTITUTION -Name(If not either, give street and Inpatient(Specify))<br><b>6997 Pinebrook Court Home</b> |  | 4. SEX<br><b>Male</b>  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 5. RACE (Specify)<br><b>White</b>   |   | 6. Hispanic Origin? Specify No -Non-Hispanic   |  | 7a. AGE-Last birthday (Years)<br><b>78</b>   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 7b. UNDER 1 YEAR<br><b>MOS</b>  |   | 7c. UNDER 1 DAY<br><b>DAYS</b>   |  | 7d. UNDER 1 HOUR<br><b>HOURS</b>   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 7e. UNDER 1 MIN<br><b>MIN</b>   |   | 8. DATE OF BIRTH (Mo/Day/Yr)<br><b>July 03, 1937</b>   |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 9a. STATE OF BIRTH (If not US/CA, name country)<br><b>Michigan</b>  |   | 9b. CITIZEN OF WHAT COUNTRY<br><b>United States</b>  |  | 10. EDUCATION<br><b>12</b>   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 11. MARITAL STATUS (Specify)<br><b>Divorced</b>   |   | 12. SURVIVING SPOUSE'S NAME (Last name prior to first marriage)  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 13. SOCIAL SECURITY NUMBER  |   | 14a. USUAL OCCUPATION (Give Kind of Work Done During Most of)<br><b>Electrician</b>  |  | 14b. KIND OF BUSINESS OR INDUSTRY<br><b>Electrician</b>  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 15a. RESIDENCE - STATE<br><b>Nevada</b>   |   | 15b. COUNTY<br><b>Clark</b>  |  | 15c. CITY, TOWN OR LOCATION<br><b>Las Vegas</b>  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 15d. STREET AND NUMBER<br><b>6997 Pinebrook Court</b>   |   | 15e. INSIDE CITY LIMITS (Specify Yes or No)<br><b>Yes</b>  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 16. FATHER/PARENT - NAME (First Middle Last Suffix)<br><b>Stephen ROWE</b>  |   |  | 17. MOTHER/PARENT - NAME (First Middle Last Suffix)<br><b>Jennie M HENDREN</b> |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 18a. INFORMANT- NAME (Type or Print)<br><b>Stephen ROWE</b>   |   | 18b. MAILING ADDRESS (Street or R.F.D. No, City or Town, State, Zip)<br><b>6997 Pinebrook Court Las Vegas, Nevada 89147</b>    |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br><b>Anatomical Donation/Cremation</b>  |   | 19b. CEMETERY OR CREMATORY - NAME<br><b>Paradise Valley Crematory</b>  |  | 19c. LOCATION City or Town State<br><b>Las Vegas Nevada 89119</b>  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 20a. FUNERAL DIRECTOR - SIGNATURE (Of Person Acting as Such)<br><b>ALLEN KOPP</b><br>SIGNATURE AUTHENTICATED  |   | 20b. FUNERAL DIRECTOR OF LICENSE NUMBER<br><b>772</b>  |  | 20c. NAME AND ADDRESS OF FACILITY<br><b>Davis Funeral Home and Memorial Park</b><br><b>6200 S Eastern Las Vegas NV 89119</b> |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 21. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)<br><b>CRAIG M JORGENSEN M.D.</b><br>SIGNATURE AUTHENTICATED   |   |  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 21b. DATE SIGNED (Mo/Day/Yr)<br><b>May 03, 2016</b>   |   | 21c. HOUR OF DEATH<br><b>20:23</b>   |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 22. 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) stated. (Signature & Title)  |   |  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 22b. DATE SIGNED (Mo/Day/Yr)  |   | 22c. HOUR OF DEATH   |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 22d. PRONOUNCED DEAD (Mo/Day/Yr)  |   | 22e. PRONOUNCED DEAD AT (Hour)   |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print)<br><b>Craig M Jorgenson-M.D. 6330 S Jones Blvd Las Vegas, NV 89118</b>  |   |  |  | 23b. LICENSE NUMBER<br><b>9529</b>   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 24a. REGISTRAR (Signature)<br><b>NANCY BARRY</b><br>SIGNATURE AUTHENTICATED   |   | 24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)<br><b>May 04, 2016</b>   |  | 24c. DEATH DUE TO COMMUNICABLE DISEASE<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)  |   |  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| PART I (a) <b>Liver Cancer</b>  |   |  |  | Interval between onset and death<br><b>Months</b>  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF:   |   |  |  | Interval between onset and death   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF:   |   |  |  | Interval between onset and death   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF:   |   |  |  | Interval between onset and death   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| (d)   |   |  |  | Interval between onset and death   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part 1.  |   |  |  | 26. AUTOPSY (Specify Yes or No)<br><b>No</b>   |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 27. WAS CASE REFERRED TO CORONER (Specify Yes or No)<br><b>Yes</b>  |   |  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 28a. ACC. SUICIDE, HOM., UNDET. OR PENDING INVEST. (Specify)  |   | 28b. DATE OF INJURY (Mo/Day/Yr)  |  | 28c. HOUR OF INJURY  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |   |  |  |  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |
| 28e. INJURY AT WORK (Specify Yes or No)   |   | 28f. PLACE OF INJURY- At home, farm, street, factory, office building, etc. (Specify)  |  | 28g. LOCATION STREET OR R.F.D. No. CITY OR TOWN STATE  |  |                                     |  |  |  |  |  |                       |  |                                   |  |  |  |  |  |                                |  |                                |  |                                  |  |                               |  |  |  |  |  |  |  |   |  |                            |  |   |  |   |  |  |  |                            |  |   |  |   |  |   |  |                             |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |   |  |                                    |  |  |  |  |  |  |  |  |  |                              |  |                    |  |  |  |                                  |  |                                |  |  |  |  |  |  |  |                                    |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |   |  |                                 |  |  |  |                                  |  |                                     |  |  |  |                                  |  |                                     |  |  |  |                                  |  |     |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                 |  |                     |  |                                   |  |  |  |  |  |   |  |   |  |   |  |

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Registrar of Vital Statistics

*Nancy Barry*

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