

STATE OF NEVADA — DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH — SECTION OF VITAL STATISTICS
CERTIFICATE OF DEATH

004336

LOCAL FILE NUMBER		STATE FILE NUMBER	
1. DECEASED—NAME First Middle Last Jerome Fargo SEARS Jr.		DATE OF DEATH (Month, Day, Year) 2 July 28, 1993	
CITY, TOWN, OR LOCATION OF DEATH Las Vegas		COUNTY OF DEATH Clark	
2. HOSPITAL OR OTHER INSTITUTION—Name (if not other, give street and number) St. Sunrise Hospital		3. Place of death, indicate DOA, Office, Home, Institution (Specify) Inpatient	
4. RACE—(e.g., White, Black, American Indian, etc.) (Specify) White		5. SEX Male	
6. Was Decedent of Hispanic Origin? Specify <input type="checkbox"/> yes <input checked="" type="checkbox"/> no 7a. 78		7. UNDER 1 YEAR UNDER 1 DAY MOS : DAYS HOURS : MINS 7c. 7c.	
8. DATE OF BIRTH (Mo., Day, Yr.) June 7, 1915		9. SURVIVING SPOUSE (if wife, give maiden name) Sandra Wahlstrom	
10. STATE OF BIRTH (if not U.S.A., name country) Utah		11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. Decedent's Education, Specify highest grade completed. 14	
14. SOCIAL SECURITY NUMBER [REDACTED]		15. USUAL OCCUPATION (Give kind of Work Done During Most of Working Life, Even if Retired) Administrator	
16. KIND OF BUSINESS OR INDUSTRY Redevelopment		17. INSIDE CITY LIMITS (Specify Yes or No) No	
18. RESIDENCE—STATE Nevada		19. COUNTY Lincoln	
20. CITY, TOWN, OR LOCATION Pioche		21. STREET AND NUMBER HC 74 Box 186	
22. FATHER—NAME First Middle Last Jerome F. Sears Sr.		23. MOTHER—MAIDEN NAME First Middle Last Louise Gabourne	
24. INFORMANT—NAME (Type or Print) Sandra Sears		25. MARITAL ADDRESS (Street or R.F.D. No., City or Town, State, Zip) HC 74, Box 186, Pioche, NV 89043	
26. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Cremation		27. CEMETERY OR CREMATORY—NAME NV Cremation or Burial Soc.	
28. FUNERAL DIRECTION (Specify) NV Cremation or Burial Society		29. NAME AND ADDRESS OF FACILITY 2121 Western Ave., A-3, L.V., NV 89102	
30. FUNERAL LICENSE NUMBER 41		31. DATE BORNED (Mo., Day, Yr.) 7/29/15	
32. HOUR OF DEATH 5:00 AM		33. DATE BORNED (Mo., Day, Yr.) 7/29/15	
34. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) Dr. Joseph M. Quagliana, M.D., 3380 S. Eastern Ave., Las Vegas, NV 89103		35. LICENSE NUMBER 2881	
36. REGISTRAR (Signature) [Signature]		37. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) JUL 29 1993	
38. IMMEDIATE CAUSE Myocardial infarction		39. DEATH DUE TO COMMUNICABLE DISEASE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
40. PART I DUE TO, OR AS A CONSEQUENCE OF: Aspiration, bacterial		41. AUTOPTSY (Specify Yes or No) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
42. PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration, bacterial		43. WAS CASE REFERRED TO CORONER (Specify Yes or No) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
44. ACC., SUICIDE, HOMIC., UNDET., OR PENDING INVEST. 28b.		45. DATE OF INJURY (Mo., Day, Yr.) 28c.	
46. HOURS OF INJURY 28d.		47. DESCRIBE HOW INJURY OCCURRED 28e.	
48. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 28f.		49. LOCATION, STREET OR R.F.D. No., CITY OR TOWN, STATE 28g.	

No.054232

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COUNTY HEALTH DISTRICT

OTTO RAVENHOLT, M.D.
Registrar of Vital Statistics

[Signature]

Date issued: JUL 30 1993

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