





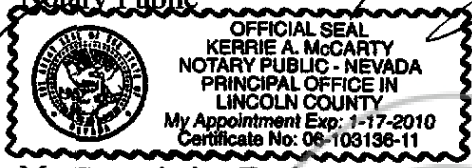
6. This affidavit is made for the purpose of terminating the joint tenancy between myself and the aforementioned decedent in the within described property, said title now vesting solely in **Jean M. Hemmings**, as her sole and separate property.

DATED this the 16 day of MAY 2009.

*Jean M. Hemmings*  
\_\_\_\_\_  
**Jean M. Hemmings**

SUBSCRIBED AND SWORN to before me on  
this 15 day of MAY 2009  
by **Jean M. Hemmings**.

*Kerrie A. McCarty*  
\_\_\_\_\_  
Notary Public



My Commission Expires:

1-17-2010



DEPARTMENT OF HUMAN RESOURCES  
 DIVISION OF HEALTH  
 VITAL STATISTICS

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

TYPE OR PRINT IN PERMANENT BLACK INK

DECEDENT

IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

PARENTS

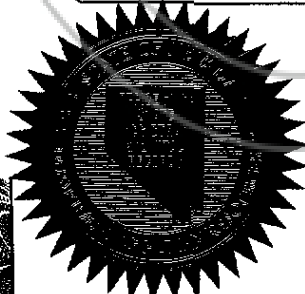
DISPOSITION

CERTIFIER

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

CAUSE OF DEATH

LOCAL FILE NUMBER		STATE FILE NUMBER	
DECEASED—NAME First Middle Last		DATE OF DEATH (Month, Day, Year)	
1. Thomas Spurgeon HEMMINGS		2. January 12, 2003	
CITY, TOWN OR LOCATION OF DEATH		COUNTY OF DEATH	
3b. Caliente		3a. Lincoln	
HOSPITAL OR OTHER INSTITUTION—Name (If not either, give street and number)		If Hosp. or Inst. indicate DOA, OP/Emer. Rm. Inpatient (Specify)	
3c. Grover C. Dils Medical Center		3e. Inpatient	
SEX		4. Male	
RACE—(e.g., White, Black, American Indian, etc.) (Specify)		Was Decedent of Hispanic Origin? Specify <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, specify Mexican, Cuban, Puerto Rican, etc.	
5. White		6.	
AGE—Last Birthday (Years)		UNDER 1 YEAR MOS : DAYS	
7a. 73		7b. :	
UNDER 1 DAY HOURS : MINS		DATE OF BIRTH (Mo., Day, Yr.)	
7c. :		8. September 10, 1929	
STATE OF BIRTH (If not U.S.A., name country)		CITIZEN OF WHAT COUNTRY	
9a. Georgia		9b. USA	
Decedent's Education. Specify highest grade completed.		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
10. 13		11. Married	
SOCIAL SECURITY NUMBER		SURVIVING SPOUSE (If wife, give maiden name)	
13. [REDACTED]		12. Jean Marie Kelley	
USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even if Retired)		KIND OF BUSINESS OR INDUSTRY	
14a. Mechanic		14b. Radiator Mechanic	
RESIDENCE—STATE		COUNTY	
15a. Nevada		15b. Lincoln	
CITY, TOWN, OR LOCATION		STREET AND NUMBER	
15c. Pioche		15d. 30 Silver St.	
INSIDE CITY LIMITS (Specify Yes or No)		15e. Yes	
FATHER—NAME First Middle Last		MOTHER—MAIDEN NAME First Middle Last	
16. Dorsey Hemmings		17. Mildred Chandler	
INFORMANT—NAME (Type or Print)		MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip)	
18a. Jean Hemmings		18b. PO Box 541 Pioche, Nevada 89043	
BURIAL, CREMATION, REMOVAL, OTHER (Specify)		CEMETERY OR CREMATORY—NAME	
19a. Burial		19b. Garden of the Resurrection	
		19c. Valley View Memorial Park	
		19c. Las Vegas Nevada	
FUNERAL DIRECTOR—SIGNATURE (Or Person Acting as Such)		FUNERAL DIRECTOR LICENSE NUMBER	
20a. [Signature]		20b. 15	
NAME AND ADDRESS OF FACILITY		CITY AND STATE	
20c. Wiscombe Funeral Home, 730 Front St. Caliente Nv.		09 89008	
21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.		22a. 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.	
(Signature and Title) [Signature]		(Signature and Title) [Signature]	
DATE SIGNED (Mo., Day, Yr.)		DATE SIGNED (Mo., Day, Yr.)	
21b. January 15, 2003		22b. :	
HOUR OF DEATH		HOUR OF DEATH	
21c. 04:10 a.m.		22c. :	
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		PRONOUNCED DEAD (Mo., Day, Yr.)	
21d.		22d. ON	
		22e. AT	
NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER). (Type or Print)		LICENSE NUMBER	
23a. Dr. Farhana Kamal M.D. P.O. Box 1010 Caliente, Nevada 89008		23b. 7903	
REGISTRAR		DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)	
24a. [Signature]		24b. January 15, 2003	
DEATH DUE TO COMMUNICABLE DISEASE		24c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)		Interval between onset and death	
PART I (a) Respiratory Failure		Hours	
DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death	
(b) Advanced Chronic Obstructed Pulmonary Disease		Years	
DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in Part I.		AUTOPSY (Specify Yes or No)	
26. Tobacco Abuse; Bacterial Pneumonia		26. No	
WAS CASE REFERRED TO CORONER (Specify Yes or No)		27. No	
ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)		DATE OF INJURY (Mo., Day, Yr.)	
28a.		28b.	
HOUR OF INJURY		DESCRIBE HOW INJURY OCCURRED	
28c. M		28d.	
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	
28e.		28f.	
LOCATION.		STREET OR R.F.D. No.	
28g.		CITY OR TOWN	
		STATE	



STATE REGISTRAR

No. 223190

This is to certify that the above is a true and correct copy of the certificate on file in this office.

*Sybil*  
 State Registrar

Date Issued:

JAN 30 2003

State Registrar