

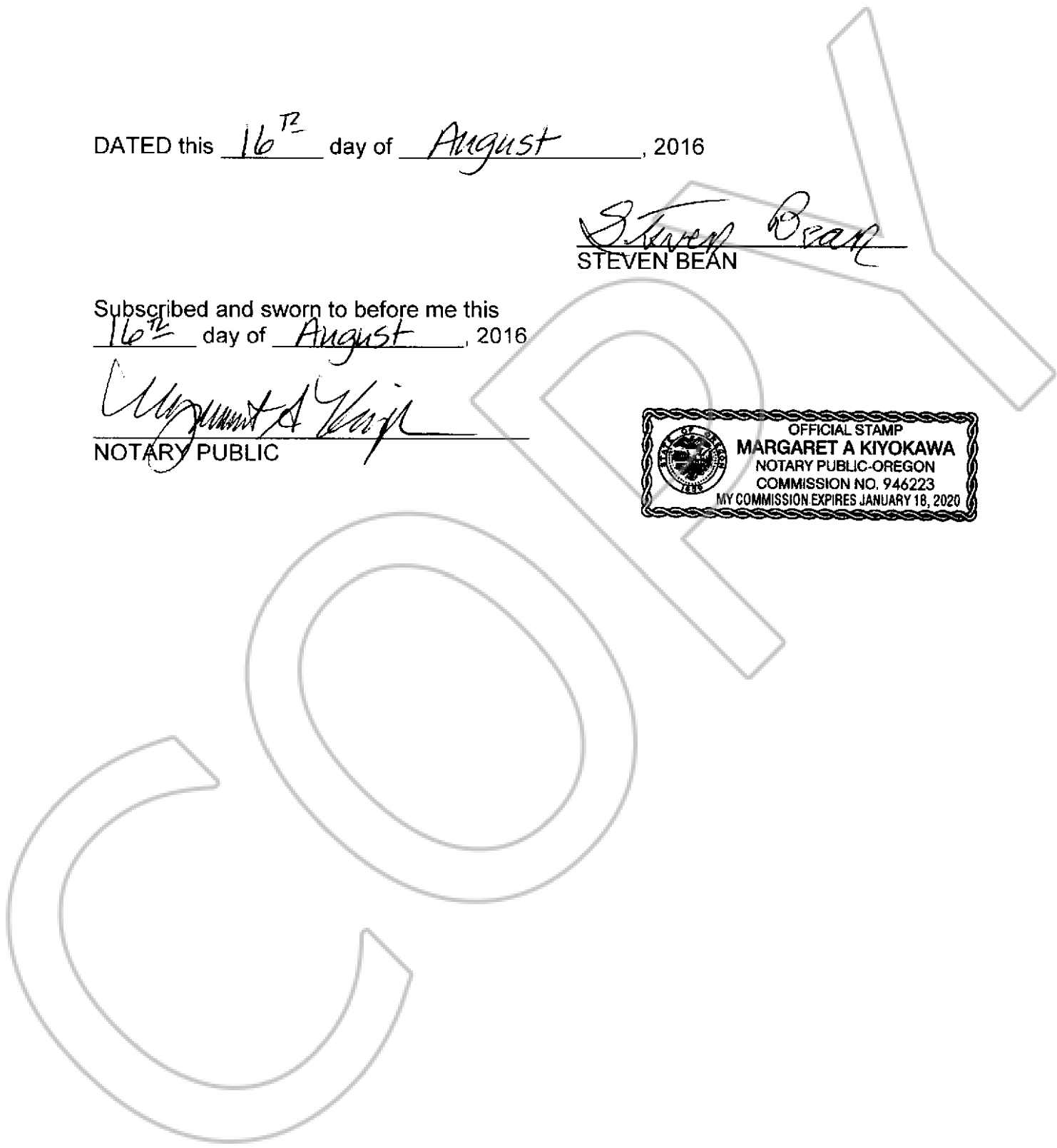


DATED this 16th day of August, 2016

Steven Bean
STEVEN BEAN

Subscribed and sworn to before me this
16th day of August, 2016

Margaret A Kiyokawa
NOTARY PUBLIC



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

CASE FILE NO. 3891084 CERTIFICATE OF DEATH 2016007653
STATE FILE NUMBER

TYPE OR PRINT IN PERMANENT BLACK INK

DECEDENT

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

PARENTS

DISPOSITION

TRADE CALL

CERTIFIER

REGISTRAR

CAUSE OF DEATH

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

1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX) Jimmie Ellsworth BEAN		2. DATE OF DEATH (Mo/Day/Year) April 26, 2016		3a. COUNTY OF DEATH Clark	
3b. CITY, TOWN, OR LOCATION OF DEATH Las Vegas		3c. HOSPITAL OR OTHER INSTITUTION -Name(if not either, give street and Nathan Adelson Hospice-Tenaya Inpatient(Specify) Hospice Facility (HFS)		4. SEX Male	
5. RACE White (Specify) White		6. Hispanic Origin? Specify No - Non-Hispanic		7a. AGE-Last birthday (Years) 89	
9a. STATE,OF BIRTH (If not US/CA, name country) Idaho		9b. CITIZEN OF WHAT COUNTRY United States		10. EDUCATION 10	
11. MARITAL STATUS (Specify) Widowed		12. SURVIVING SPOUSE'S NAME (Last name prior to first marriage)		7b. UNDER 1 YEAR MOS DAYS	
13. SOCIAL SECURITY NUMBER [REDACTED]		14a. USUAL OCCUPATION (Give Kind of Work Done During Most of Heavy Equipment Operator		7c. UNDER 1 DAY HOURS MIN	
14b. KIND OF BUSINESS OR INDUSTRY Construction		15a. RESIDENCE - STATE Nevada		8. DATE OF BIRTH (Mo/Day/Yr) June 26, 1926	
15b. COUNTY Lincoln		15c. CITY, TOWN OR LOCATION Pioche		15d. STREET AND NUMBER 483 Timber Crest Way	
15e. INSIDE CITY LIMITS (Specify Yes or No) No		16. FATHER/PARENT - NAME (First Middle Last Suffix) Rolland E BEAN		17. MOTHER/PARENT - NAME (First Middle Last Suffix) Pearl Sarah KUCKKU	
18a. INFORMANT- NAME (Type or Print) Susan Anne SECREST		18b. MAILING ADDRESS (Street or R.F.D. No, City or Town, State, Zip) HC 74 Box 111 Pioche, Nevada 89043			
19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Burial		19b. CEMETERY OR CREMATORY - NAME Palm Northwest Cemetery		19c. LOCATION City or Town State Las Vegas Nevada 89131	
20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such) MICHAEL TOTH SIGNATURE AUTHENTICATED		20b. FUNERAL DIRECTOR LICENSE NUMBER 858		20c. NAME AND ADDRESS OF FACILITY Palm Mortuary-Northwest 6701 N. Jones Blvd. Las Vegas NV 89131	
TRADE CALL - NAME AND ADDRESS					
21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.(Signature & Title) GOPALAKRISHNA LEELA MD SIGNATURE AUTHENTICATED		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) stated. (Signature & Title)			
21b. DATE SIGNED (Mo/Day/Yr) April 27, 2016		21c. HOUR OF DEATH 11:05		22b. DATE SIGNED (Mo/Day/Yr)	
21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		22c. HOUR OF DEATH		22d. PRONOUNCED DEAD (Mo/Day/Yr)	
21e. PRONOUNCED DEAD AT (Hour)		23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print) Gopalakrishna Leela MD 3150 N Tenaya Las Vegas, NV 89128			
23b. LICENSE NUMBER 11458		24a. REGISTRAR (Signature) NANCY BARRY SIGNATURE AUTHENTICATED			
24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr) April 28, 2016		24c. DEATH DUE TO COMMUNICABLE DISEASE 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) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ DUE TO, OR AS A CONSEQUENCE OF: (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) No
27. WAS CASE REFERRED TO CORONER (Specify Yes or No) Yes					
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	

LOCAL REGISTRAR

"CERTIFIED TO BE A TRUE AND CORRECT COPY OF THE DOCUMENT ON FILE WITH THE REGISTRAR OF VITAL STATISTICS, STATE OF NEVADA." This copy was issued by the Southern Nevada Health District from State certified documents authorized by state Board of Health pursuant to NRS 440.175.

VRS-Rev-20120523a



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DATE ISSUED: **MAY 05 2016**
This copy not valid unless prepared on watermarked security paper displaying date, seal and signature of Registrar.
SOUTHERN NEVADA HEALTH DISTRICT • P.O. Box 3902 • Las Vegas, NV 89127 • 702-759-1010 • Tax ID # 88-0151573

Registrar of Vital Statistics
By: *Nancy Barry*

