



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

000971

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 000971		STATE FILE NUMBER	
DECEASED—NAME First Middle Last 1. Warren W. REED		DATE OF DEATH (Month, Day, Year) 2. January 22, 1998	
CITY, TOWN, OR LOCATION OF DEATH 3b. Las Vegas		COUNTY OF DEATH 3a. Clark	
HOSPITAL OR OTHER INSTITUTION—Name (If not either, give street and number) 3c. Sunrise Mountainview Hospital		If Hosp. or Inst. Indicate DOA, OP/Emer. Rm. Inpatient (Specify) 3e. Inpatient	
RACE—(e.g., White, Black, American Indian, etc.) (Specify) 5. White		SEX 4. Male	
Was Decedent of Hispanic Origin? Specify <input type="checkbox"/> yes <input checked="" type="checkbox"/> no 6.		AGE—Last Birthday (Years) 7a. 80	
STATE OF BIRTH (If not U.S.A., name country) 9a. California		CITIZEN OF WHAT COUNTRY 9b. U.S.A.	
SOCIAL SECURITY NUMBER 13. [REDACTED] 8182		Decedent's Education. Specify highest grade completed. 10. 14	
USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even if Retired) 14a. Insurance Agent / Retired		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 11. Married	
RESIDENCE—STATE 15a. Nevada		SURVIVING SPOUSE (If wife, give maiden name) 12. Ethlyn Summers	
COUNTY 15b. Douglas		KIND OF BUSINESS OR INDUSTRY 14b. Insurance	
CITY, TOWN, OR LOCATION 15c. Minden		STREET AND NUMBER 15d. 228 8th Street	
MOTHER—MAIDEN NAME First Middle Last 17. Maimie Minor		INSIDE CITY LIMITS (Specify Yes or No) 15e. Yes	
FATHER—NAME First Middle Last 16. Frank Reed		MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) 18b. P O Box 1 Minden Nevada 89423	
INFORMANT—NAME (Type or Print) 18a. Alan Reed - Son		CEMETERY OR CREMATORY—NAME 19b. Palm Crematory	
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. Cremation		LOCATION City or Town State 19c. Las Vegas, Nevada	
FUNERAL DIRECTOR—SIGNATURE (Or Person Acting as Such) 20a. [Signature]		NAME AND ADDRESS OF FACILITY 20c. Palm Mortuary - Cheyenne 7400 W. Cheyenne Rd., Las Vegas, Nevada 89129	
FUNERAL DIRECTOR LICENSE NUMBER 20b. 50		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.	
21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) [Signature] DATE SIGNED (Mo., Day, Yr.) 21b. 1-28-98		22b. 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] DATE SIGNED (Mo., Day, Yr.) 22c. [Blank]	
HOUR OF DEATH 21c. 8:45 PM		HOUR OF DEATH 22c. [Blank]	
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) 21d. [Blank]		PRONOUNCED DEAD (Mo., Day, Yr.) 22d. ON	
22e. AT		22e. AT	
NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER), (Type or Print.) 23a. Michael Gross M.D. 1750 East Desert Inn Rd. Las Vegas, NV 89109		LICENSE NUMBER 23b. 5398	
REGISTRAR 24a. [Signature]		DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) 24b. JAN 30 1998	
25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) PART I (a) <i>Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (c) OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in Part I.		DEATH DUE TO COMMUNICABLE DISEASE 24c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Interval between onset and death 25a. <i>2 weeks</i>		Interval between onset and death 25b. <i>2 weeks</i>	
Interval between onset and death 25c. [Blank]		Interval between onset and death 25d. [Blank]	
AUTOPSY (Specify Yes or No) 26. No		WAS CASE REFERRED TO CORONER (Specify Yes or No) 27. No	
ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 28a.		DATE OF INJURY (Mo., Day, Yr.) 28b.	
HOUR OF INJURY 28c. M		DESCRIBE HOW INJURY OCCURRED 28d.	
INJURY AT WORK (Specify Yes or No) 28e.		PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 28f.	
LOCATION. 28g.		STREET OR R.F.D. No. CITY OR TOWN STATE	

STATE REGISTRAR

No. 120640

"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 Clark County Health District from State certified documents as authorized by the State Board of Health pursuant to NRS 440.175.

NOT VALID WITHOUT THE RAISED SEAL OF THE CLARK COUNTY HEALTH DISTRICT

OTTO RAVENHOLT, M.D.  
 Registrar of Vital Statistics

By: [Signature]

Date Issued: APR 30 1998

SEAL

CLARK COUNTY HEALTH DISTRICT  
 625 Shadow Lane P.O. Box 4426  
 Las Vegas, Nevada 89127  
 702-383-1223

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COPY

REQUESTED BY  
Alan Reed  
IN OFFICIAL RECORDS OF  
DOUGLAS CO., NEVADA

'98 OCT 20 P4:45

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LINDA SLATER  
RECORDER  
\$9<sup>00</sup> PAID Ko DEPUTY