

Requested By:
Diamond Resorts
Douglas County - NV
Karen Ellison - Recorder
Page: 1 of 2 Fee: \$15.00
BK-613 PG-94 RPTT: 0.00



RECORDING REQUESTED BY

And when recorded mail to:
S. Schacter
Diamond Resorts
10600 W. Charleston Blvd.
Las Vegas, NV 89135

Space above this line for Recorder's Use

AFFIDAVIT - DEATH OF JOINT TENANT

Scott A. Hogue, of legal age, being first duly sworn, deposes, and says:

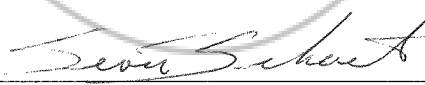
That RICHARD GEORGE ALLEN, the decedent mentioned in the attached Original Certificate of Death, is the same person as one of the parties in that certain GRANT, BARGAIN, SALE DEED dated Mar 11, 2003, executed by RICHARD G. ALLEN SR and DOLORES M ALLEN, husband and wife, recorded as Instrument No. 0571080 BK-0303 PG-11468, on 5/29/2001, of Official Records of **Douglas County**, Nevada covering the following described property situated in the County of Douglas, State of Nevada.

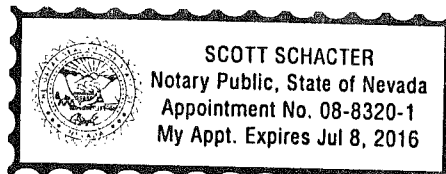

SCOTT A. HOGUE

Dated: JUN 3, 2013

State: Nevada
County: Clark

Subscribed and sworn to before me, this 3RD day of JUNE, 2013. SCOTT A. HOGUE
he/she/they is/are personally known to me or has/have produced _____ as identification.


Scott Schacter - Notary



SEAL



VALID ONLY
WITH
IMPRESSED
SEAL

I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE COPY OF A
RECORD ON FILE IN THE DIVISION OF VITAL RECORDS.

DATE ISSUED:

OCT. 02, 06

STATE REGISTRAR OF VITAL RECORDS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No.

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD GEORGE ALLEN		2. Date of Death Month SEP Day 26 Year 2006		3. Time of Death 5:05 P M	
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER		4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 1061	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	8. Date of Birth (Month, Day, Year) 12-19-1937	9. Birthplace (State or Foreign Country) PA	
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State MD	10b. County PG	10c. City, Town or Location Fort Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1601 Skipjack Drive		10f. Zip Code 20744	10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pastor		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Theodore Holiday			18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Briggs			
19a. Informant's Name/Relationship (Type, Print) Dolores Allen/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Skipjack Dr., Ft. Washington, MD 2074				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l		Date 10-11-06	20c. Location - City or Town, State Arlington, VA	
21. Signature of Funeral Service Licensee Ronald [Signature]		22. Name and Address of Facility Taylor's Funeral Home 1722 North Capitol St. NW Wash. DC 20001				
Physician / Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CLOSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of):					
	c. Due to (or as a consequence of):					
	d. Due to (or as a consequence of):					
IF FEMALE 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE ON CHRONIC RENAL FAILURE				23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: 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 as stated.		29b. Signature and title of certifier [Signature] MD		29c. License number 01054801A (IN)	29d. Date signed (Month, Day, Year) 9/27/06	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS G. HAWK LCDR MC USN		NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600				
State Registrar	31. Date filed (Month, Day, Year) OCT 02 2006	32. Registrar's Signature [Signature]				

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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