

161

Doc Number: **0834066**

11/19/2013 01:41 PM

OFFICIAL RECORDS

Requested By:  
**JOSEPH W TILLSON**

DOUGLAS COUNTY RECORDERS  
Karen Ellison - Recorder

Page: 1 of 3 Fee: \$ 16.00

Bk: 1113 Pg: 3898



Deputy gb

Document Transfer Tax \$0  
Assessor's Parcel No. 1418-27-811-006

WHEN RECORDED AND  
MAIL TAX STATEMENTS TO:  
✓ Virginia Matus Glenn and  
Michael A. Matus, Co-Trustees  
15819 W Avalon Drive  
Goodyear, AZ 8332

The grantor declares:  
Documentary transfer tax is \$ -0-  
 computed on full value of property conveyed,

**AFFIDAVIT--DEATH OF SETTLOR, TRUSTEE AND BENEFICIARY**

VIRGINIA MATUS GLENN and MICHAEL A. MATUS, of legal age, being first duly sworn, depose and say:

That JOHN A. MATUS, the decedent mentioned in the attached certified copy of Certificate of Death, is the same person as is named as the party in that certain Grant, Bargain and Sale Deed dated October 13, 2011, executed by JOHN A. MATUS, wherein the decedent is the settlor of THE JOHN A. MATUS FAMILY TRUST dated October 22, 1984, as well as the beneficiary and trustee under said trust; it being further acknowledged that VIRGINIA MATUS GLENN and MICHAEL A. MATUS are the successor trustees under said declaration of trust on the death of JOHN A. MATUS.

The original Grant, Bargain and Sale Deed aforementioned is recorded as Document No.0791901 on November 1, 2011, in the Official Records of Douglas County, State of Nevada, covering the following described property situate in the County of Douglas, State of Nevada:

Lot 60, as shown on the map of CAVE ROCK ESTATES UNIT NO. 2, filed in the office of the County Recorder of Douglas County, Nevada, on July 29, 1968.

Dated: Oct 22, 2013

Virginia Matus Glenn  
VIRGINIA MATUS GLENN

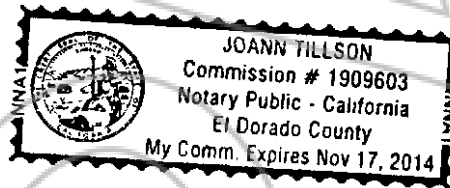
Michael A. Matus  
MICHAEL A. MATUS

JURAT

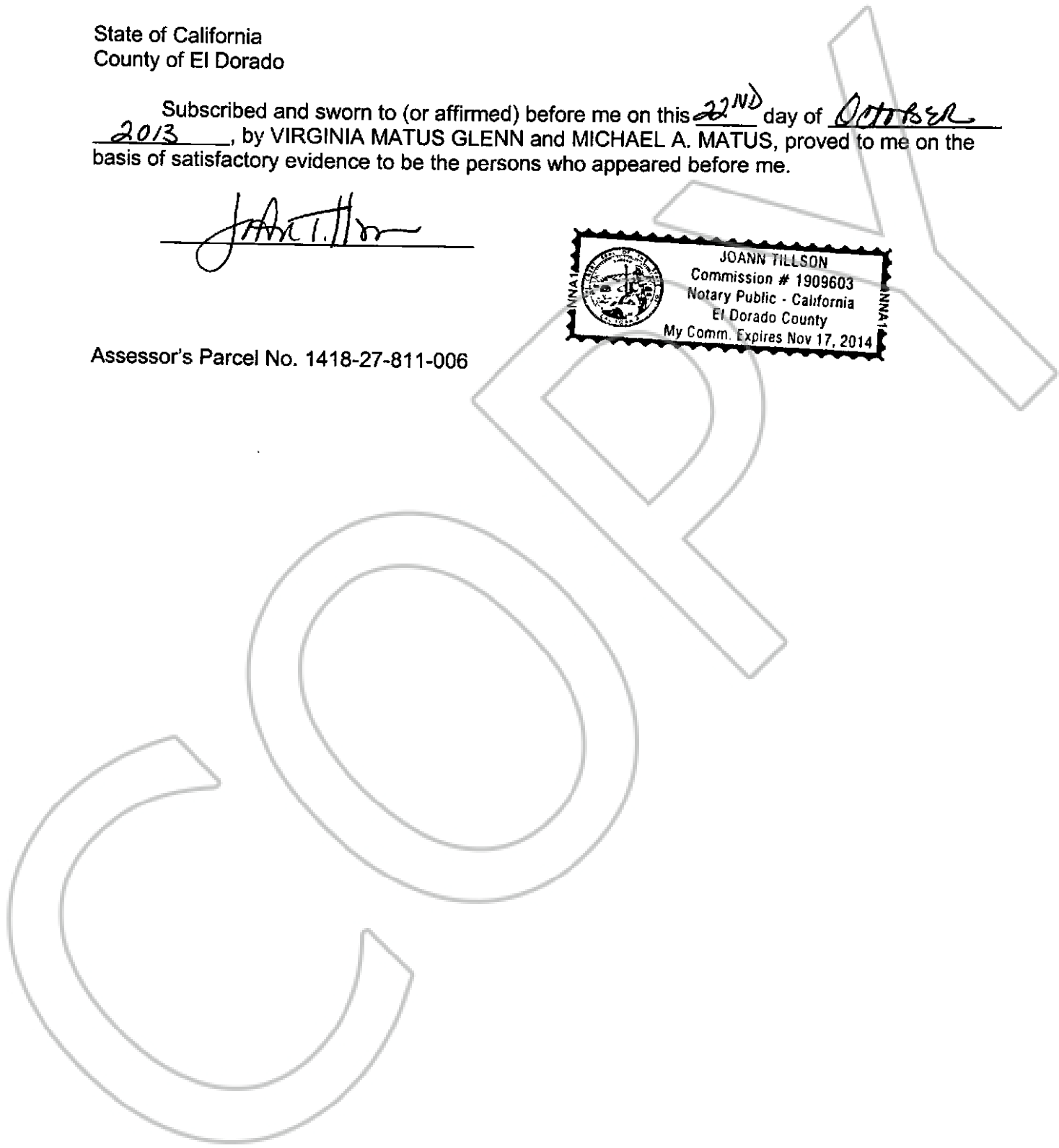
State of California  
County of El Dorado

Subscribed and sworn to (or affirmed) before me on this 22<sup>ND</sup> day of October  
2013, by VIRGINIA MATUS GLENN and MICHAEL A. MATUS, proved to me on the  
basis of satisfactory evidence to be the persons who appeared before me.

Joann Tillson



Assessor's Parcel No. 1418-27-811-006



# STATE OF NEVADA

## CERTIFICATION OF VITAL RECORD

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### DIVISION OF HEALTH VITAL STATISTICS

### CERTIFICATE OF DEATH

2013015722

STATE FILE NUMBER

|   |  |  |  |   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---------------------------------------|--|---|--|---|--|--|--|-----------------------|--|-----------------------------------|--|---|--|--|--|---|--|---------------------------------|--|--|--|--|--|---|--|----------------------------|--|---|--|--|--|---|--|---|--|---|--|---|--|-------------------------------|--|--|--|--|--|---|--|-------------------------------------|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|--|--|--|--|---|--|------------------------------------|--|---|--|--|--|------------------------------|--|--------------------|--|--|--|-------------------------------------|--|---|--|--|--|---|--|---|--|--------|--|--|--|--|--|--|--|---------------------------------|--|----------------------------------|--|--|--|-------------|--|----------------------------------|--|--|--|-------------|--|----------------------------------|--|---------|--|--|--|--|--|--|--|---|--|---------------------------------|--|---------------------|--|-----------------------------------|--|---|--|---|--|---|--|--|--|
| TYPE OR PRINT IN PERMANENT BLACK INK<br><br>IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS<br><br>PARENTS<br><br>DISPOSITION<br><br>TRADE CALL<br><br>CERTIFIER<br><br>REGISTRAR<br><br>CAUSE OF DEATH<br><br>CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX)<br/><b>John A MATUS</b></td> <td colspan="2">2. DATE OF DEATH (Mo/Day/Year)<br/><b>September 24, 2013</b></td> <td colspan="2">3a. COUNTY OF DEATH<br/><b>Douglas</b></td> </tr> <tr> <td colspan="2">3b. CITY, TOWN, OR LOCATION OF DEATH<br/><b>Gardnerville</b></td> <td colspan="2">3c. HOSPITAL OR OTHER INSTITUTION -Name(if not either, give street and number)<br/><b>Carson Valley Residential Care</b></td> <td colspan="2">3e. If Hosp. or Inst. indicate DOA, OP, Emer. Rm. Inpatient(Specify)<br/><b>Residential Care Facility</b></td> </tr> <tr> <td colspan="2">4. SEX<br/><b>Male</b></td> <td colspan="2">5. RACE <b>White</b><br/>(Specify)</td> <td colspan="2">6. Hispanic Origin? Specify<br/><b>No - Non-Hispanic</b></td> </tr> <tr> <td colspan="2">7a. AGE-Last birthday (Years)<br/><b>99</b></td> <td colspan="2">7b. UNDER 1 YEAR<br/>MOS   DAYS   HOURS   MINS</td> <td colspan="2">7c. UNDER 1 DAY<br/>HOURS   MINS</td> </tr> <tr> <td colspan="2">8. DATE OF BIRTH (Mo/Day/Yr)<br/><b>August 27, 1914</b></td> <td colspan="2">9a. STATE OF BIRTH (if not U.S.A. name country)<br/><b>California</b></td> <td colspan="2">9b. CITIZEN OF WHAT COUNTRY<br/><b>United States</b></td> </tr> <tr> <td colspan="2">10. EDUCATION<br/><b>14</b></td> <td colspan="2">11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br/><b>Widowed</b></td> <td colspan="2">12. SURVIVING SPOUSE (If wife, give maiden name)</td> </tr> <tr> <td colspan="2">13. SOCIAL SECURITY NUMBER<br/><b>1259</b></td> <td colspan="2">14a. USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even If Retired)<br/><b>Scenic Artist</b></td> <td colspan="2">14b. KIND OF BUSINESS OR INDUSTRY<br/><b>Movies &amp; Television</b></td> </tr> <tr> <td colspan="2">15a. RESIDENCE - STATE<br/><b>Nevada</b></td> <td colspan="2">15b. COUNTY<br/><b>Douglas</b></td> <td colspan="2">15c. CITY, TOWN OR LOCATION<br/><b>Gardnerville</b></td> </tr> <tr> <td colspan="2">15d. STREET AND NUMBER<br/><b>1189 Kimmerling Rd.</b></td> <td colspan="2">15e. INSIDE CITY LIMITS (Specify Yes or No)<br/><b>Yes</b></td> <td colspan="2">Ever in US Armed Forces? <b>Yes</b></td> </tr> <tr> <td colspan="3">16. FATHER/PARENT - NAME (First Middle Last Suffix)<br/><b>Andrew MATUS</b></td> <td colspan="3">17. MOTHER/PARENT - NAME (First Middle Last Suffix)<br/><b>Mary GRUCELLA</b></td> </tr> <tr> <td colspan="3">18a. INFORMANT - NAME (Type or Print)<br/><b>Virginia MATUS-GLENN</b></td> <td colspan="3">18b. MAILING ADDRESS (Street or R.F.D. No. City or Town, State, Zip)<br/><b>PO Box 15220 South Lake Tahoe, California 96151</b></td> </tr> <tr> <td colspan="2">19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br/><b>Cremation</b></td> <td colspan="2">19b. CEMETERY OR CREMATORY - NAME<br/><b>Walton's Sierra Crematory</b></td> <td colspan="2">19c. LOCATION City or Town State<br/><b>Carson City Nevada 89706</b></td> </tr> <tr> <td colspan="2">20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such)<br/><b>CURT KOESTLER</b></td> <td colspan="2">20b. FUNERAL DIRECTOR LICENSE<br/><b>823</b></td> <td colspan="2">20c. NAME AND ADDRESS OF FACILITY<br/><b>Walton's Funerals and Cremations<br/>1521 Church Street Gardnerville NV 89410</b></td> </tr> <tr> <td colspan="6">21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature &amp; Title)<br/><b>REED DOPF M.D.</b></td> </tr> <tr> <td colspan="2">21b. DATE SIGNED (Mo/Day/Yr)<br/><b>September 27, 2013</b></td> <td colspan="2">21c. HOUR OF DEATH<br/><b>22:50</b></td> <td colspan="2">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 &amp; Title)</td> </tr> <tr> <td colspan="2">21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)</td> <td colspan="2">22b. DATE SIGNED (Mo/Day/Yr)</td> <td colspan="2">22c. HOUR OF DEATH</td> </tr> <tr> <td colspan="2">23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print)<br/><b>Reed Dopf M.D. 18653 Wedge Pkwy Reno, NV 89511</b></td> <td colspan="2">23b. LICENSE NUMBER<br/><b>13920</b></td> <td colspan="2">24a. REGISTRAR (Signature)<br/><b>NICOLE SHORE</b></td> </tr> <tr> <td colspan="2">24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)<br/><b>September 27, 2013</b></td> <td colspan="2">24c. DEATH DUE TO COMMUNICABLE DISEASE<br/>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></td> <td colspan="2">25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))</td> </tr> <tr> <td colspan="2">PART I</td> <td colspan="2">(a) <b>Terminal complications of Alzheimers, Type Dementia</b></td> <td colspan="2">Interval between onset and death<br/><b>Years</b></td> </tr> <tr> <td colspan="2"></td> <td colspan="2">(b) <b>Etiology Unspecified</b></td> <td colspan="2">Interval between onset and death</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">(c) <b></b></td> <td colspan="2">Interval between onset and death</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">(d) <b></b></td> <td colspan="2">Interval between onset and death</td> </tr> <tr> <td colspan="2">PART II</td> <td colspan="2">OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part I.<br/><b>Atherosclerotic and Hypertensive Vascular Disease</b></td> <td colspan="2">26. AUTOPSY (Specify Yes or No)<br/><b>No</b></td> </tr> <tr> <td colspan="2">27. WAS CASE REFERRED TO CORONER (Specify Yes or No)<br/><b>Yes</b></td> <td colspan="2">28a. ACC., SUICIDE, HON., UNDET OR PENDING INVEST (Specify)</td> <td colspan="2">28b. DATE OF INJURY (Mo/Day/Yr)</td> </tr> <tr> <td colspan="2">28c. HOUR OF INJURY</td> <td colspan="2">28d. DESCRIBE HOW INJURY OCCURRED</td> <td colspan="2">28e. INJURY AT WORK (Specify Yes or No)</td> </tr> <tr> <td colspan="2">28f. PLACE OF INJURY- At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="2">28g. LOCATION STREET OR R.F.D. No. CITY OR TOWN STATE</td> <td colspan="2"></td> </tr> </table> | 1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX)<br><b>John A MATUS</b>  |  | 2. DATE OF DEATH (Mo/Day/Year)<br><b>September 24, 2013</b>   |  | 3a. COUNTY OF DEATH<br><b>Douglas</b> |  | 3b. CITY, TOWN, OR LOCATION OF DEATH<br><b>Gardnerville</b> |  | 3c. HOSPITAL OR OTHER INSTITUTION -Name(if not either, give street and number)<br><b>Carson Valley Residential Care</b> |  | 3e. If Hosp. or Inst. indicate DOA, OP, Emer. Rm. Inpatient(Specify)<br><b>Residential Care Facility</b> |  | 4. SEX<br><b>Male</b> |  | 5. RACE <b>White</b><br>(Specify) |  | 6. Hispanic Origin? Specify<br><b>No - Non-Hispanic</b> |  | 7a. AGE-Last birthday (Years)<br><b>99</b> |  | 7b. UNDER 1 YEAR<br>MOS   DAYS   HOURS   MINS |  | 7c. UNDER 1 DAY<br>HOURS   MINS |  | 8. DATE OF BIRTH (Mo/Day/Yr)<br><b>August 27, 1914</b> |  | 9a. STATE OF BIRTH (if not U.S.A. name country)<br><b>California</b> |  | 9b. CITIZEN OF WHAT COUNTRY<br><b>United States</b> |  | 10. EDUCATION<br><b>14</b> |  | 11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> |  | 12. SURVIVING SPOUSE (If wife, give maiden name) |  | 13. SOCIAL SECURITY NUMBER<br><b>1259</b> |  | 14a. USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even If Retired)<br><b>Scenic Artist</b> |  | 14b. KIND OF BUSINESS OR INDUSTRY<br><b>Movies &amp; Television</b> |  | 15a. RESIDENCE - STATE<br><b>Nevada</b> |  | 15b. COUNTY<br><b>Douglas</b> |  | 15c. CITY, TOWN OR LOCATION<br><b>Gardnerville</b> |  | 15d. STREET AND NUMBER<br><b>1189 Kimmerling Rd.</b> |  | 15e. INSIDE CITY LIMITS (Specify Yes or No)<br><b>Yes</b> |  | Ever in US Armed Forces? <b>Yes</b> |  | 16. FATHER/PARENT - NAME (First Middle Last Suffix)<br><b>Andrew MATUS</b> |  |  | 17. MOTHER/PARENT - NAME (First Middle Last Suffix)<br><b>Mary GRUCELLA</b> |  |  | 18a. INFORMANT - NAME (Type or Print)<br><b>Virginia MATUS-GLENN</b> |  |  | 18b. MAILING ADDRESS (Street or R.F.D. No. City or Town, State, Zip)<br><b>PO Box 15220 South Lake Tahoe, California 96151</b> |  |  | 19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br><b>Cremation</b> |  | 19b. CEMETERY OR CREMATORY - NAME<br><b>Walton's Sierra Crematory</b> |  | 19c. LOCATION City or Town State<br><b>Carson City Nevada 89706</b> |  | 20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such)<br><b>CURT KOESTLER</b> |  | 20b. FUNERAL DIRECTOR LICENSE<br><b>823</b> |  | 20c. NAME AND ADDRESS OF FACILITY<br><b>Walton's Funerals and Cremations<br/>1521 Church Street Gardnerville NV 89410</b> |  | 21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)<br><b>REED DOPF M.D.</b> |  |  |  |  |  | 21b. DATE SIGNED (Mo/Day/Yr)<br><b>September 27, 2013</b> |  | 21c. HOUR OF DEATH<br><b>22:50</b> |  | 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) |  | 21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) |  | 22b. DATE SIGNED (Mo/Day/Yr) |  | 22c. HOUR OF DEATH |  | 23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print)<br><b>Reed Dopf M.D. 18653 Wedge Pkwy Reno, NV 89511</b> |  | 23b. LICENSE NUMBER<br><b>13920</b> |  | 24a. REGISTRAR (Signature)<br><b>NICOLE SHORE</b> |  | 24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)<br><b>September 27, 2013</b> |  | 24c. DEATH DUE TO COMMUNICABLE DISEASE<br>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) <b>Terminal complications of Alzheimers, Type Dementia</b> |  | Interval between onset and death<br><b>Years</b> |  |  |  | (b) <b>Etiology Unspecified</b> |  | Interval between onset and death |  |  |  | (c) <b></b> |  | Interval between onset and death |  |  |  | (d) <b></b> |  | Interval between onset and death |  | PART II |  | OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic and Hypertensive Vascular Disease</b> |  | 26. AUTOPSY (Specify Yes or No)<br><b>No</b> |  | 27. WAS CASE REFERRED TO CORONER (Specify Yes or No)<br><b>Yes</b> |  | 28a. ACC., SUICIDE, HON., 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 |  |  |  |
| 1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX)<br><b>John A MATUS</b>   |  | 2. DATE OF DEATH (Mo/Day/Year)<br><b>September 24, 2013</b>  |  | 3a. COUNTY OF DEATH<br><b>Douglas</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 3b. CITY, TOWN, OR LOCATION OF DEATH<br><b>Gardnerville</b>   |  | 3c. HOSPITAL OR OTHER INSTITUTION -Name(if not either, give street and number)<br><b>Carson Valley Residential Care</b>  |  | 3e. If Hosp. or Inst. indicate DOA, OP, Emer. Rm. Inpatient(Specify)<br><b>Residential Care Facility</b>  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 4. SEX<br><b>Male</b>   |  | 5. RACE <b>White</b><br>(Specify)  |  | 6. Hispanic Origin? Specify<br><b>No - Non-Hispanic</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 7a. AGE-Last birthday (Years)<br><b>99</b>  |  | 7b. UNDER 1 YEAR<br>MOS   DAYS   HOURS   MINS  |  | 7c. UNDER 1 DAY<br>HOURS   MINS   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 8. DATE OF BIRTH (Mo/Day/Yr)<br><b>August 27, 1914</b>  |  | 9a. STATE OF BIRTH (if not U.S.A. name country)<br><b>California</b>   |  | 9b. CITIZEN OF WHAT COUNTRY<br><b>United States</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 10. EDUCATION<br><b>14</b>  |  | 11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>  |  | 12. SURVIVING SPOUSE (If wife, give maiden name)  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 13. SOCIAL SECURITY NUMBER<br><b>1259</b>   |  | 14a. USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even If Retired)<br><b>Scenic Artist</b>  |  | 14b. KIND OF BUSINESS OR INDUSTRY<br><b>Movies &amp; Television</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 15a. RESIDENCE - STATE<br><b>Nevada</b>   |  | 15b. COUNTY<br><b>Douglas</b>  |  | 15c. CITY, TOWN OR LOCATION<br><b>Gardnerville</b>  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 15d. STREET AND NUMBER<br><b>1189 Kimmerling Rd.</b>  |  | 15e. INSIDE CITY LIMITS (Specify Yes or No)<br><b>Yes</b>  |  | Ever in US Armed Forces? <b>Yes</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 16. FATHER/PARENT - NAME (First Middle Last Suffix)<br><b>Andrew MATUS</b>  |  |  | 17. MOTHER/PARENT - NAME (First Middle Last Suffix)<br><b>Mary GRUCELLA</b>  |   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 18a. INFORMANT - NAME (Type or Print)<br><b>Virginia MATUS-GLENN</b>  |  |  | 18b. MAILING ADDRESS (Street or R.F.D. No. City or Town, State, Zip)<br><b>PO Box 15220 South Lake Tahoe, California 96151</b> |   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)<br><b>Cremation</b>  |  | 19b. CEMETERY OR CREMATORY - NAME<br><b>Walton's Sierra Crematory</b>  |  | 19c. LOCATION City or Town State<br><b>Carson City Nevada 89706</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such)<br><b>CURT KOESTLER</b>  |  | 20b. FUNERAL DIRECTOR LICENSE<br><b>823</b>  |  | 20c. NAME AND ADDRESS OF FACILITY<br><b>Walton's Funerals and Cremations<br/>1521 Church Street Gardnerville NV 89410</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)<br><b>REED DOPF M.D.</b>   |  |  |  |   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 21b. DATE SIGNED (Mo/Day/Yr)<br><b>September 27, 2013</b>   |  | 21c. HOUR OF DEATH<br><b>22:50</b>   |  | 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) |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)  |  | 22b. DATE SIGNED (Mo/Day/Yr)   |  | 22c. HOUR OF DEATH  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print)<br><b>Reed Dopf M.D. 18653 Wedge Pkwy Reno, NV 89511</b>  |  | 23b. LICENSE NUMBER<br><b>13920</b>  |  | 24a. REGISTRAR (Signature)<br><b>NICOLE SHORE</b>   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)<br><b>September 27, 2013</b>  |  | 24c. DEATH DUE TO COMMUNICABLE DISEASE<br>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) <b>Terminal complications of Alzheimers, Type Dementia</b>   |  | Interval between onset and death<br><b>Years</b>  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
|   |  | (b) <b>Etiology Unspecified</b>  |  | Interval between onset and death  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
|   |  | (c) <b></b>  |  | Interval between onset and death  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
|   |  | (d) <b></b>  |  | Interval between onset and death  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| PART II   |  | OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic and Hypertensive Vascular Disease</b> |  | 26. AUTOPSY (Specify Yes or No)<br><b>No</b>  |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |
| 27. WAS CASE REFERRED TO CORONER (Specify Yes or No)<br><b>Yes</b>  |  | 28a. ACC., SUICIDE, HON., 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  |  |   |  |                                       |  |   |  |   |  |  |  |                       |  |                                   |  |   |  |  |  |   |  |                                 |  |  |  |  |  |   |  |                            |  |   |  |  |  |   |  |   |  |   |  |   |  |                               |  |  |  |  |  |   |  |                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |   |  |   |  |  |  |   |  |   |  |   |  |  |  |  |  |   |  |                                    |  |   |  |  |  |                              |  |                    |  |  |  |                                     |  |   |  |  |  |   |  |   |  |        |  |  |  |  |  |  |  |                                 |  |                                  |  |  |  |             |  |                                  |  |  |  |             |  |                                  |  |         |  |  |  |  |  |  |  |   |  |                                 |  |                     |  |                                   |  |   |  |   |  |   |  |  |  |

STATE REGISTRAR

0834055 Page 3 of 3

BK 1113  
PG 3900  
11/19/2013

VRS-Rev-20120523a

### CERTIFIED COPY OF VITAL RECORDS

This is a true and exact reproduction of the document officially registered and placed on file in the office of the State Registrar and Vital Records.

DATE ISSUED: **10/02/2013**

This copy is not valid unless prepared on engraved border displaying date, seal and signature of Registrar.

*Reed Dopf*  
SIGNATURE AUTHENTICATED

