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| A.P.N. No.: | 1420-07-214-005 |
| File No.: | 2177010 MMB |
| Recording Requested By: | |
| Stewart Title Company | |
| When Recorded Mail To: | |
| Karen Hutchins, Successor Trustee of The Keith D. Hall Living Trust dated February 15, 2004 | |
| 188 Artesia Rd. | |
| Wellington, NV 89444 | |

| | |
|----------------------------|---------------------|
| DOUGLAS COUNTY, NV | 2023-1002544 |
| Rec:\$40.00 | 11/21/2023 09:20 AM |
| \$40.00 Pgs=4 | |
| STEWART TITLE COMPANY - NV | |
| SHAWNYNE GARREN, RECORDER | |

(for recorders use only)


AFFIDAVIT DEATH OF TRUSTEE (Title of Document)

Please complete Affirmation Statement below:

- I the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording does not contain the social security number of any person or persons. (Per NRS 239B.030)

-OR-

- I the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording does contain the social security number of a person or persons as required by law: NRS 440.380(1)(A) and NRS 40.525(5)



 Signature Escrow Officer
 Title

Miranda Bowlen
Print Signature

This page added to provide additional information required by NRS 111.312 Sections 1 - 2 and NRS 239B.030 Section 4.

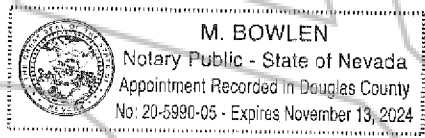
The Keith D. Hall Living Trust

By: Karen Hutchins
Karen Hutchins, Successor Trustee

State of Nevada
County of Douglas

Subscribed and sworn to (or affirmed) before me on this 10th day of November, 2023 by
Karen Hutchins.

Signature M. Bowlen (Seal)



COPY

STATE OF NEVADA
CERTIFICATION OF VITAL RECORD

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

CASE FILE NO. 4376179

CERTIFICATE OF DEATH

2023022968
STATE FILE NUMBER

| | | | | | | |
|--|--|---|---|---|---|--|
| TYPE OR PRINT IN PERMANENT BLACK INK | 1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX) Keith Donald HALL | | 2. DATE OF DEATH (Mo/Day/Year) October 18, 2023 | | 3a. COUNTY OF DEATH Carson City | |
| | 3b. CITY, TOWN, OR LOCATION OF DEATH Carson City | | 3c. HOSPITAL OR OTHER INSTITUTION -Name(If not either, give street and number) Whispering Heights | | 3d. If Hosp. or Inst. indicate DOA,OP/Emer. Rm. Inpatient(Specify) Assisted Living Facility | |
| DECEDENT | 4. SEX Male | | 5. RACE (Specify) White | | 6. DATE OF BIRTH (Mo/Day/Yr) April 09, 1940 | |
| | 7a. AGE-Last birthday (Years) 83 | | 7b. UNDER 1 YEAR MOS DAYS | | 7c. UNDER 1 DAY HOURS MINS | |
| IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS | 9a. STATE OF BIRTH (If not US/CA, name country) California | | 9b. CITIZEN OF WHAT COUNTRY UNITED STATES | | 10. EDUCATION 12 | |
| | 11. MARITAL STATUS (Specify) Divorced | | 12. SURVIVING SPOUSE'S NAME (Last name prior to first marriage) | | | |
| PARENTS | 13. SOCIAL SECURITY NUMBER ██████████2602 | | 14a. USUAL OCCUPATION (Give Kind of Work Done During Most of) | | 14b. KIND OF BUSINESS OR INDUSTRY | |
| | 15a. RESIDENCE - STATE Nevada | | 15b. COUNTY Douglas | | 15c. CITY, TOWN OR LOCATION Wellington | |
| DISPOSITION | 15d. STREET AND NUMBER 188 Artesia Rd | | 15e. INSIDE CITY LIMITS (Specify Yes or No) No | | | |
| | 16. FATHER/PARENT - NAME (First Middle Last Suffix) Lawrence HALL | | | 17. MOTHER/PARENT - NAME (First Middle Last Suffix) Elaine EBERHARD | | |
| TRADE CALL | 18a. INFORMANT- NAME (Type or Print) Karen HUTCHINS | | 18b. MAILING ADDRESS (Street or R.F.D. No, City or Town, State, Zip) 188 Artesia Rd Wellington, Nevada 89444 | | | |
| | 19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Cremation | | 19b. CEMETERY OR CREMATORY - NAME Walton's Sierra Crematory | | 19c. LOCATION City or Town State Carson City Nevada 89706 | |
| CERTIFIER | 20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such) CARLEN THOMAS SIGNATURE AUTHENTICATED | | 20b. FUNERAL DIRECTOR LICENSE NUMBER FD861 | | 20c. NAME AND ADDRESS OF FACILITY Waltons Funerals & Cremations-Chapel of the Valley 1281 N Roop Carson City NV 89706 | |
| | 21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title) JOSEPH W HEFLIN JR MD SIGNATURE AUTHENTICATED | | | | | |
| REGISTRAR | 21b. DATE SIGNED (Mo/Day/Yr) October 22, 2023 | | 21c. HOUR OF DEATH 15:15 | | | |
| | 21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) | | 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) | | | |
| CAUSE OF DEATH | 22b. DATE SIGNED (Mo/Day/Yr) | | 22c. HOUR OF DEATH | | | |
| | 22d. PRONOUNCED DEAD (Mo/Day/Yr) | | 22e. PRONOUNCED DEAD AT (Hour) | | | |
| CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST | 23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print) Joseph W Heflin Jr MD 1600 Medical Parkway Carson City, NV 89703 | | | | 23b. LICENSE NUMBER 15218 | |
| | 24a. REGISTRAR (Signature) WESLEY T STOREY SIGNATURE AUTHENTICATED | | 24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr) October 23, 2023 | | 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 | | | | Interval between onset and death | |
| | (a) Chronic Diastolic Congestive Heart Failure | | | | Interval between onset and death | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | Interval between onset and death | | |
| (b) Coronary Artery Disease | | | | Interval between onset and death | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | Interval between onset and death | | |
| (c) Pulmonary Hypertension | | | | Interval between onset and death | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | Interval between onset and death | | |
| (d) Sleep Apnea | | | | 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) No | | | | | | |
| 28a. ACC., SUICIDE, HGM, 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 | | |



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.

Cody D. Storey

DATE ISSUED: **10/24/2023**

STATE REGISTRAR

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

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

