

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

3052014190289

CERTIFICATE OF DEATH

3201419042462

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT- FIRST (Given) ELIZABETH		2. MIDDLE M.	
3. LAST (Family) PENA		4. DATE OF BIRTH mm/dd/yyyy 09/23/1959	
5. AGE Yrs. 55		6. SEX F	
9. BIRTH STATE/FOREIGN COUNTRY NJ		10. SOCIAL SECURITY NUMBER [REDACTED]	
11. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK		12. MARITAL STATUS/SDRP* (at Time of Death) MARRIED	
13. EDUCATION - Highest Level/Degree (see worksheet on back) HS GRADUATE		14/15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back) <input checked="" type="checkbox"/> YES CUBAN	
16. DECEDENT'S RACE - Up to 3 races may be listed (see worksheet on back) CAUCASIAN		17. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED ACTRESS	
18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.) ENTERTAINMENT		19. YEARS IN OCCUPATION 40	
20. DECEDENT'S RESIDENCE (Street and number, or location) [REDACTED]		21. CITY TOPANGA	
22. COUNTY/PROVINCE LOS ANGELES		23. ZIP CODE [REDACTED]	
24. YEARS IN COUNTY 29		25. STATE/FOREIGN COUNTRY CA	
26. INFORMANT'S NAME, RELATIONSHIP HANS ROLLA, HUSBAND		27. INFORMANT'S MAILING ADDRESS (Street and number, or post route number, city or town, state and zip) [REDACTED]	
28. NAME OF SURVIVING SPOUSE/SDRP*-FIRST HANS		29. MIDDLE CHRISTIAN	
30. LAST (BIRTH NAME) ROLLA		31. NAME OF FATHER/PARENT-FIRST MARIO	
32. MIDDLE [REDACTED]		33. LAST PENA-SANCHEZ	
34. BIRTH STATE CUBA		35. NAME OF MOTHER/PARENT-FIRST ESTELLA	
36. MIDDLE MARGARITA		37. LAST (BIRTH NAME) TOIRAC	
38. BIRTH STATE CUBA		39. DISPOSITION DATE: mm/dd/yyyy 10/17/2014	
40. PLACE OF FINAL DISPOSITION [REDACTED]		41. TYPE OF DISPOSITION(S) CR/RES	
42. SIGNATURE OF CORONER [REDACTED]		43. LICENSE NUMBER [REDACTED]	
44. NAME OF FUNERAL ESTABLISHMENT NEPTUNE SOCIETY		45. LICENSE NUMBER FD 1359	
46. SIGNATURE OF LOCAL REGISTRAR [REDACTED]		47. DATE: mm/dd/yyyy 10/17/2014	
101. PLACE OF DEATH CEDARS SINAI MEDICAL CENTER		102. IF HOSPITAL, SPECIFY ONE <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> EROV <input type="checkbox"/> DOA <input type="checkbox"/> Hospice <input type="checkbox"/> Nursing Home/LTC <input type="checkbox"/> Resident's Home <input type="checkbox"/> Other	
104. COUNTY LOS ANGELES		105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location) 8700 BEVERLY BOULEVARD	
106. CITY LOS ANGELES		107. CAUSE OF DEATH Enter the chain of events - disease, injury, or complication - that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or convulsive asphyxia without showing the etiology. DO NOT abbreviate. (A) CARDIOPULMONARY ARREST (B) CARDIOGENIC SHOCK (C) ACUTE GASTROINTESTINAL BLEEDING (D) CIRRHOSIS OF THE LIVER DUE TO ALCOHOL	
108. DEATH REPORTED TO CORONER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO REFERRAL NUMBER [REDACTED]		109. BIOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
110. AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		111. USED IN DETERMINING CAUSE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107 NONE		113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.) NO	
114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attended Since: Decedent Last Seen Alive: (A) mm/dd/yyyy: 10/07/2014 (B) mm/dd/yyyy: 10/14/2014		115. SIGNATURE AND TITLE OF CERTIFIER [REDACTED]	
116. LICENSE NUMBER A101511		117. DATE: mm/dd/yyyy 10/16/2014	
118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE JULIE WEGGE, M.D. [REDACTED]		119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. MANNER OF DEATH <input type="checkbox"/> Nature <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	
120. INJURED AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		121. INJURY DATE: mm/dd/yyyy [REDACTED]	
122. HOUR (24 Hours) [REDACTED]		123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.) [REDACTED]	
124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury) [REDACTED]		125. LOCATION OF INJURY (Street and number, or location, and city, and zip) [REDACTED]	
126. SIGNATURE OF CORONER / DEPUTY CORONER [REDACTED]		127. DATE: mm/dd/yyyy [REDACTED]	
128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER [REDACTED]		129. SIGNATURE OF REGISTRAR [REDACTED]	

This is a true certified copy of the record filed in the County of Los Angeles
Department of Public Health. It bears the Registrar's signature in purple ink.

Director of Public Health and Registrar

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

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE