

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

3052016258287

CERTIFICATE OF DEATH

3201619057895

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT - FIRST, (Given)		3. LAST (Family)	
MARY		REYNOLDS	
2. MIDDLE		4. DATE OF BIRTH mm/dd/yyyy	
FRANCES		04/01/1932	
5. AGE Yrs.		6. SEX	
84		F	
7. DATE OF DEATH mm/dd/yyyy		8. HOUR (24 Hours)	
12/28/2016		1739	
9. BIRTH STATE/FOREIGN COUNTRY		10. SOCIAL SECURITY NUMBER	
TX		[REDACTED]	
11. EVER IN U.S. ARMED FORCES?		12. MARITAL STATUS/SRDP (at Time of Death)	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK		DIVORCED	
13. EDUCATION - Highest Level/Degree (see worksheet on back)		14. WAS DECEDENT HISPANIC/LATINO/SPANISH? (if yes, see worksheet on back)	
DOCTORATE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15. DECEDENT'S RACE - Up to 3 races may be listed (see worksheet on back)		16. DECEDENT'S RACE - Up to 3 races may be listed (see worksheet on back)	
CAUCASIAN		CAUCASIAN	
17. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED		18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	
ACTRESS		ENTERTAINMENT INDUSTRY	
19. YEARS IN OCCUPATION		20. DECEDENT'S RESIDENCE (Street and number, or location)	
68		[REDACTED]	
21. CITY		22. COUNTY/PROVINCE	
[REDACTED]		CLARK	
23. ZIP CODE		24. YEARS IN COUNTY	
[REDACTED]		36	
25. STATE/FOREIGN COUNTRY		26. INFORMANT'S NAME, RELATIONSHIP	
NV		TODD E. FISHER, SON	
27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)		28. NAME OF SURVIVING SPOUSE/SRDP - FIRST	
[REDACTED]		-	
29. MIDDLE		30. LAST (BIRTH NAME)	
-		-	
31. NAME OF FATHER/PARENT - FIRST		32. MIDDLE	
RAYMOND		FRANCIS	
33. NAME OF MOTHER/PARENT - FIRST		34. BIRTH STATE	
MINNIE		TX	
35. MIDDLE		36. BIRTH STATE	
MAXENE		OK	
37. LAST (BIRTH NAME)		38. BIRTH STATE	
HARMON		OK	
39. DISPOSITION DATE mm/dd/yyyy		40. PLACE OF FINAL DISPOSITION	
01/06/2017		FOREST LAWN MEMORIAL PARK	
41. TYPE OF DISPOSITION(S)		42. SIGNATURE OF EMPALMER	
BU		[REDACTED]	
43. LICENSE NUMBER		44. NAME OF FUNERAL ESTABLISHMENT	
EMB8704		PIERCE BROTHERS WESTWOOD	
45. LICENSE NUMBER		46. SIGNATURE OF LOCAL REGISTRAR	
FD951		[REDACTED]	
47. DATE mm/dd/yyyy		48. DATE mm/dd/yyyy	
01/04/2017		01/04/2017	
101. PLACE OF DEATH		102. IF HOSPITAL, SPECIFY ONE	
CEDARS-SINAI MEDICAL CENTER		<input checked="" type="checkbox"/> IP <input type="checkbox"/> LOF <input type="checkbox"/> DOA	
103. IF OTHER THAN HOSPITAL, SPECIFY ONE		104. CITY	
[REDACTED]		LOS ANGELES	
105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)		106. CITY	
[REDACTED]		LOS ANGELES	
107. CAUSE OF DEATH		108. DEATH REPORTED TO CORONER?	
IMMEDIATE CAUSE (Final disease or condition resulting in death)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
(A) INTRACEREBRAL HEMORRHAGE		109. BIOPSY PERFORMED?	
(B) HYPERTENSION		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
110. AUTOPSY PERFORMED?		111. USED IN DETERMINING CAUSE?	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107		113. WAS OPERATIONAL PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)	
NONE		NO	
114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.		115. SIGNATURE AND TITLE OF CERTIFIER	
[REDACTED]		[REDACTED]	
116. LICENSE NUMBER		117. DATE mm/dd/yyyy	
A104423		12/30/2016	
118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE		119. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE	
ASMA MAHAVASH MOHEET M.D.		ASMA MAHAVASH MOHEET M.D.	
120. INJURED AT WORK?		121. INJURY DATE mm/dd/yyyy	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		[REDACTED]	
122. HOUR (24 Hours)		123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)	
[REDACTED]		[REDACTED]	
124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)		125. LOCATION OF INJURY (Street and number, or location, and city, and zip)	
[REDACTED]		[REDACTED]	
126. SIGNATURE OF CORONER / DEPUTY CORONER		127. DATE mm/dd/yyyy	
[REDACTED]		[REDACTED]	
128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER		129. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER	
[REDACTED]		[REDACTED]	

STATE REGISTRAR	A	B	C	D	E	FAV AUTH.#	CENSUS TRACT

This is a true certified copy of the record filed in the County of Los Angeles Department of Public Health if 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



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JAN - 9 2017

DATE ISSUED

