

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

305201000070

CERTIFICATE OF DEATH

3201019000186

STATE FILE NUMBER 305201000070		STATE OF CALIFORNIA USE BLACK INK ONLY / NO ERASURES, WHITE-OUTS OR ALTERATIONS VS 1 (REV 5/06)		LOCAL REGISTRATION NUMBER 3201019000186				
DECEDENT'S PERSONAL DATA	1. NAME OF DECEDENT - FIRST (Given) SALE TROTTER CASE		2. MIDDLE -		3. LAST (Family) JOHNSON			
	AKA. ALSO KNOWN AS - Include full AKA (FIRST, MIDDLE, LAST) CASEY JOHNSON			4. DATE OF BIRTH mm/dd/yyyy 09/24/1979		5. AGE Yrs. 30 IF UNDER ONE YEAR: Months _____ Days _____ IF UNDER 24 HOURS: Hours _____ Minutes _____		
	9. BIRTH STATE/FOREIGN COUNTRY FL		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/SRDP* (at Time of Death) NEVER MARRIED	
	13. EDUCATION - Highest Level/Degree HS GRADUATE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		14/15. WAS DECEDENT HISPANIC/LATINO/SPANISH? (If yes, see worksheet on back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		16. DATE OF DEATH mm/dd/yyyy 01/04/2010		17. HOURS (24 Hours) 1147	
USUAL RESIDENCE	17. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED ARTIST			18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.) ENTERTAINMENT		19. YEARS IN OCCUPATION 10		
	20. DECEDENT'S RESIDENCE (Street and number, or location) [REDACTED]							
	21. CITY LOS ANGELES		22. COUNTY/PROVINCE LOS ANGELES		23. ZIP CODE [REDACTED]		24. YEARS IN COUNTY 8	
	25. STATE/FOREIGN COUNTRY CA		26. INFORMANT'S NAME, RELATIONSHIP ROBERT WOOD JOHNSON IV, FATHER		27. INFORMANT'S MAILING ADDRESS [REDACTED]		28. NAME OF SURVIVING SPOUSE/SRDP - FIRST -	
SPOUSE/SRDP AND PARENT INFORMATION	29. MIDDLE -		30. LAST (BIRTH NAME) -		31. NAME OF FATHER/PARENT - FIRST ROBERT		32. MIDDLE WOOD	
	33. LAST (BIRTH NAME) JOHNSON IV		34. BIRTH STATE NJ		35. NAME OF MOTHER/PARENT - FIRST NANCY		36. MIDDLE SALE	
	37. LAST (BIRTH NAME) FRYE		38. BIRTH STATE MO		39. DISPOSITION DATE mm/dd/yyyy 01/07/2010		40. PLACE OF FINAL DISPOSITION THE MATHER HODGE FUNERAL HOME	
	41. TYPE OF DISPOSITION(S) TR		42. SIGNATURE OF EMERALD [REDACTED]		43. LICENSE NUMBER EMB9025		44. NAME OF FUNERAL ESTABLISHMENT CALLANAN & WOODS-SCOVERN	
PLACE OF DEATH	45. DATE 01/06/2010		46. TYPE OF DEATH RESIDENCE		47. DATE mm/dd/yyyy 01/06/2010		48. TYPE OF DEATH RESIDENCE	
	101. PLACE OF DEATH LOS ANGELES		102. IF HOSPITAL, SPECIFY ONE <input type="checkbox"/> ER/OP <input type="checkbox"/> DOA <input type="checkbox"/> Hospice		103. IF OTHER THAN HOSPITAL, SPECIFY ONE <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Home <input type="checkbox"/> Other		104. COUNTY LOS ANGELES	
	105. CITY LOS ANGELES		106. FACILITY ADDRESS OR LOCATION WHERE BOUND (Street and number, or location) [REDACTED]		107. CAUSE OF DEATH Enter the chain of specific diseases, injuries or complications that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or hemiparesis. If applicable, list each without showing the etiology. DO NOT ABBREVIATE. DEFERRED		108. DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
	109. BIOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		110. AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		111. USED IN DETERMINING CAUSE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107 NONE	
PHYSICIAN'S CERTIFICATION	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 (A) mm/dd/yyyy (B) mm/dd/yyyy		115. SIGNATURE AND TITLE OF CERTIFIER [REDACTED]		116. LICENSE NUMBER [REDACTED]	
	117. DATE mm/dd/yyyy 01/06/2010		118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE [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"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		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 REGINA M AUGUSTINE		127. DATE mm/dd/yyyy 01/06/2010		128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER [REDACTED]	
STATE REGISTRAR		A B C D E		FAX 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.

Jonathan E. Fielding MD
 Director of Public Health and Registrar

JAN 12 2010 00000145*

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

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

