

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3201736000664

STATE FILE NUMBER		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT - FIRST (Given) JOHN		3. LAST (Family) [REDACTED]	
2. MIDDLE [REDACTED]		4. AGE, Yrs. Mths. Ds. 70	
5. AKA, ALSO KNOWN AS - (Include full AKA FIRST, MIDDLE, LAST)		6. SEX M	
8. BIRTH STATE/FOREIGN COUNTRY WA		9. SOCIAL SECURITY NUMBER [REDACTED]	
11. EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		12. MARITAL STATUS (Date of Death) MARRIED	
13. EDUCATION - Highest Level/Degree MASTER'S		14. WAS DECEDENT HISPANIC/LATINO/SPANISH? (If yes, see checked on back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
17. USUAL OCCUPATION - Type of work for most of life, DO NOT USE RETIRED		18. DECEDENT'S RACE - Use 1 to 3 races may be listed (see worksheet on back) CAUCASIAN	
19. BUSINESS CONSULTANT		18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.) HEALTHCARE	
20. DECEDENT'S RESIDENCE (Street and number, or location)		19. YEARS IN OCCUPATION 20	
21. CITY RIALTO		22. COUNTY/PROVINCE SAN BERNARDINO	
23. ZIP CODE 92376		24. YEARS IN COUNTY 33	
25. STATE/FOREIGN COUNTRY CA		26. STATE/FOREIGN COUNTRY CA	
27. INFORMANT'S NAME, RELATIONSHIP C [REDACTED] WIFE		28. (Same last name, or last name, number, city or town, state and zip) RIALTO, CA 92376	
29. NAME OF SURVIVING SPOUSE/SPO - FIRST [REDACTED]		30. MIDDLE JANE	
31. NAME OF FATHER/PARENT - FIRST [REDACTED]		32. MIDDLE JACKSON	
33. NAME OF MOTHER/PARENT - FIRST R [REDACTED]		34. MIDDLE LORENE	
35. DISPOSITION DATE mm/dd/yyyy 02/10/2017		36. PLACE OF FINAL DISPOSITION [REDACTED]	
37. TYPE OF DISPOSITIONS CR/BU		38. SIGNATURE OF EMBALMER NOT EMBALMED	
39. NAME OF FUNERAL ESTABLISHMENT RUBIDOUX MORTUARY		40. LICENSE NUMBER ED913	
41. SIGNATURE OF LOCAL REGISTRAR MAXWELL OHIKHUARE, MD		42. DATE mm/dd/yyyy 01/24/2017	
101. PLACE OF DEATH BROOKSIDE HEALTHCARE CENTER		102. IF HOSPITAL, SPECIFY ONE <input type="checkbox"/> ID <input type="checkbox"/> SKIN <input type="checkbox"/> BURN <input type="checkbox"/> HANGING <input checked="" type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER	
103. COUNTY SAN BERNARDINO		104. FACILITY ADDRESS OR LOCATION (Where found - Street and number, or location) 105 TERRACINA BLVD	
105. CITY REDLANDS		106. CAUSE OF DEATH IMMEDIATE CAUSE - iv CARDIOPULMONARY FAILURE CORONARY ARTERY DISEASE PARKINSONS DISEASE	
107. CAUSE OF DEATH IMMEDIATE CAUSE - iv CARDIOPULMONARY FAILURE CORONARY ARTERY DISEASE PARKINSONS DISEASE		108. PERIOD BETWEEN ONSET AND DEATH (MINS) 109. DOPOBY PERFORMED? 110. AUTOPSY PERFORMED? 111. LACED BY (STRAINING) CAUSE?	
112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE (GIVEN IN 107) PARKINSONS DISEASE		113. IF FEMALE, PREGNANT IN LAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	
114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED. Decedent Attested Since: 05/16/2016 Decedent Last Seen Alive: 01/09/2017		115. SIGNATURE AND TITLE OF CERTIFIER JEAN-CLAUDE HAGE M.D.	
116. TYPE AND DIO PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE JEAN-CLAUDE HAGE M.D. 399 E HIGHLAND AVE STE 222, SAN BERNARDINO, CA 92404		117. LICENSE NUMBER G77308	
118. DATE mm/dd/yyyy 01/24/2017		119. DATE mm/dd/yyyy 01/24/2017	
120. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		121. INJURED AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	
122. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)		123. INJURY DATE mm/dd/yyyy	
124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)		124. HOUR (24 Hour)	
125. LOCATION OF INJURY (Street and number, or location, and city, and zip)		125. SIGNATURE OF CORONER/DEPUTY CORONER	
126. SIGNATURE OF CORONER/DEPUTY CORONER		127. DATE mm/dd/yyyy	
128. TYPE NAME, TITLE OF CORONER/DEPUTY CORONER		129. TYPE NAME, TITLE OF CORONER/DEPUTY CORONER	
STATE REGISTRAR		FAX AUTH#	
A B C D E		CENSUS TRACT	



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STATE OF CALIFORNIA, COUNTY OF SAN BERNARDINO
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DATE ISSUED JAN 31 2017

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Maxwell Ohikhuare
MAXWELL OHIKHUARE, MD
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

