

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

3052013125235

CERTIFICATE OF DEATH

3201319028287

STATE FILE NUMBER		STATE OF CALIFORNIA USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS VS-1 (REV. 2008)		LOCAL REGISTRATION NUMBER	
1. NAME OF DECEDENT - FIRST (Given) JEAN		2. MIDDLE SELBY		3. LAST (Family) MAUCIERI	
AKA, ALSO KNOWN AS - Include MR, AKA, FIRST, MIDDLE, LAST		4. DATE OF BIRTH mm/dd/yyyy 07/18/1914		5. AGE Yrs. 98	
6. BIRTH STATE/FOREIGN COUNTRY ND		7. SOCIAL SECURITY NUMBER [REDACTED]		8. SEX F	
9. EVER IN U.S. ARMED FORCES? ☐ YES ☒ NO ☐ UNK		10. MARITAL STATUS/POSP at time of death WIDOWED		11. DATE OF DEATH mm/dd/yyyy 06/29/2013	
12. EDUCATION - Highest Level/Degree HS GRADUATE		13. WAS DECEDENT HISPANIC/LATINO/SPANISH? (If yes, see instructions on back) ☐ YES ☒ NO		14. DECEDENT'S RACE - Up to 3 races may be listed (see instructions on back) CAUCASIAN	
15. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED HOMEMAKER		16. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.) OWN HOME		17. YEARS IN OCCUPATION 71	
18. DECEDENT'S RESIDENCE (Street and number, or location) 12229 DUNOON LANE					
19. CITY LOS ANGELES		20. COUNTY/PROVINCE LOS ANGELES		21. ZIP CODE 90049	
22. YEARS IN COUNTY 65		23. STATE/FOREIGN COUNTRY CA			
24. INFORMANT'S NAME, RELATIONSHIP SELBY SCALBERG, DAUGHTER			25. INFORMANT'S MAILING ADDRESS (Street and number, or hotel, route number, city or town, state and ZIP) 176 MAL PASO RD, CARMEL, CA 93923		
26. NAME OF SURVIVING SPOUSE/POSP - FIRST -		27. MIDDLE -		28. LAST (BIRTH NAME) -	
29. NAME OF FATHER/PARENT - FIRST ALBERT		30. MIDDLE EDGAR		31. LAST SELBY	
32. NAME OF MOTHER/PARENT - FIRST HAZEL		33. MIDDLE IRENE		34. LAST BARRINGTON	
35. DATE OF DISPOSITION mm/dd/yyyy 07/08/2013		36. PLACE OF FINAL DISPOSITION RESIDENCE: SHELBY SEALBERG 176 MAL PASO RD, CARMEL, CA 93923		37. SIGNATURE OF EMERALMER NOT EMBALMED	
38. TYPE OF DISPOSITION CR/RES		39. NAME OF FUNERAL ESTABLISHMENT PIERCE BROTHERS WESTWOOD VILLAGE MEMORIAL PARK & MORTUARY		40. LICENSE NUMBER FD951	
41. SIGNATURE OF LOCAL REGISTRAR JONATHAN FIELDING, MD		42. DATE mm/dd/yyyy 07/02/2013		43. LICENSE NUMBER 508	
101. PLACE OF DEATH RESIDENCE		102. IF HOSPITAL, SPECIFY ONE ☐ Inpatient ☐ Outpatient ☐ Other		103. IF OTHER THAN HOSPITAL, SPECIFY ONE ☐ Nursing Home/LTC ☒ Decedent's Home ☐ Other	
104. COUNTY LOS ANGELES		105. FACILITY ADDRESS OR LOCATION (Include County, street and number, or location) 12229 DUNOON LANE		106. CITY LOS ANGELES	
107. CAUSE OF DEATH Enter the chain of events - diseases, injuries, or complications - that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. END STAGE CEREBRAL DEGENERATION		108. TIME ELAPSED BETWEEN ONSET AND DEATH 6 MOS		109. DEATH REPORTED TO CORONER? ☐ YES ☒ NO	
110. UNDERLYING CAUSE OF DEATH SENILE DEMENTIA		111. TIME ELAPSED BETWEEN ONSET AND DEATH 6 MOS		112. SPOUSE PERFORMED? ☐ YES ☒ NO	
113. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107 NONE		114. AUTOPSY PERFORMED? ☐ YES ☒ NO		115. USED IN DETERMINING CAUSE? ☐ YES ☒ NO	
116. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 113? (If yes, list type of operation and date) NO		117. IF FEMALE, PRESENT IN LAST YEAR? ☐ YES ☒ NO ☐ UNK			
118. SIGNATURE AND TITLE OF CERTIFIER BRIAN MADDEN, M.D.		119. TYPE AT (FURNISH PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE) BRIAN MADDEN, M.D. 16830 VENTURA BLVD. #315, ENCINO, CA 91436		120. LICENSE NUMBER A70323	
121. DATE mm/dd/yyyy 10/19/2012		122. DATE mm/dd/yyyy 06/29/2013		123. INJURY DATE mm/dd/yyyy 07/01/2013	
124. MANNER OF DEATH ☐ Natural ☐ Accident ☐ Femicide ☐ Suicide ☐ Pending Investigation ☐ Cause not determined ☐ YES ☐ NO ☐ UNK		125. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)		126. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)	
127. LOCATION OF INJURY (Street and number, or location, and city, and ZIP)		128. SIGNATURE OF CORONER / DEPUTY CORONER		129. DATE mm/dd/yyyy	
130. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER		131. STATE REGISTRAR		132. FAX AUTH. #	

This is a true certified copy if 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
DO 19

Director of Public Health and Registrar



JUL - 5 2013

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

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

