

CERTIFICATION OF VITAL RECORD

COUNTY OF ORANGE
HEALTH CARE AGENCY

1719 W. 17TH STREET • SANTA ANA, CALIFORNIA 92706

CERTIFICATE OF DEATH 3-95-30-016341

STATE FILE NUMBER		STATE OF CALIFORNIA USE 9-4-88 AND ONLY TWO BLANKS WITHOUTS OR ALTERATIONS 10-11 (REV. 7-93)		LOCAL REGISTRATION NUMBER	
1 NAME OF DECEDENT - FIRST (Given)		2 MIDDLE		3 LAST (Family)	
Charles		Schatz		Schatz	
6 DATE OF BIRTH MM/DD/CCYY		8 AGE YRS		7 SEX	
12/12/1903		91		Male	
9 STATE OF BIRTH		10 SOCIAL SECURITY NO		11 MILITARY SERVICE	
Lith.		313-34-2959		NONE	
12 RACE		13 HISPANIC - SPECIFY		14 MARRIAGE STATUS	
Cauc		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Widowed	
15 OCCUPATION		16 END OF BUSINESS		17 YEARS OF EDUCATION	
Sales		Auto. Parts		23	
20 RESIDENCE - STREET AND NUMBER OR LOCATION					
27256 Bellogente					
21 CITY		22 COUNTY		23 ZIP CODE	
Mission Viejo		Orange		92692	
24 STATE OR FOREIGN COUNTRY		25 YEAR IN COUNTY			
Calif.		17			
26 NAME RELATIONSHIP					
Mary Ann Sommers - Daughter					
27 MAILING ADDRESS (STREET AND NUMBER OR RURAL ROUTE NUMBER CITY OR TOWN, STATE, ZIP)					
2140 Ronda Granda Laguna Hills Ca. 92653					
28 NAME OF SURVIVING SPOUSE - FIRST					
-					
29 MIDDLE					
-					
30 LAST (MARRIAGE NAME)					
-					
31 NAME OF FATHER - FIRST					
Samuel					
32 MIDDLE					
-					
33 LAST					
Schatz					
34 BIRTH STATE					
Russia					
35 NAME OF MOTHER - FIRST					
Rochel					
36 MIDDLE					
-					
37 LAST (MARRIAGE NAME)					
Unk.					
38 BIRTH STATE					
Russia					
39 DATE MM/DD/CCYY					
12/11/1995					
40 PLACE OF FINAL DISPOSITION					
Pacific View Mem. Park Newport Beach Calif.					
41 TYPE OF DISPOSITION					
Burial					
42 SIGNATURE OF EMBALMER					
Not Embalmed					
43 LICENSE NO.					
-					
44 NAME OF FUNERAL DIRECTOR					
Chevra Kadisha Mortuary					
45 LICENSE NO.					
Fd-1326					
46 SIGNATURE OF LOCAL REGISTRAR					
[Signature]					
47 DATE MM/DD/CCYY					
12/11/1995					
101 PLACE OF DEATH					
Mission Hosp. Reg. Med. Ctr					
102 IF HOSPITAL, SPECIFY ONE:					
<input checked="" type="checkbox"/> IP <input type="checkbox"/> ER/OP <input type="checkbox"/> DOA <input type="checkbox"/> HOME HOSP <input type="checkbox"/> RES <input type="checkbox"/> OTHER					
103 COUNTY					
Orange					
104 CITY					
Mission Viejo					
105 STREET ADDRESS - STREET AND NUMBER OR LOCATION					
27700 Medical Ctr. Rd.					
106 DEATH WAS CAUSED BY - ENTER ONLY ONE CAUSE PER LAW FOR A, B, C, AND D:					
IMMEDIATE CAUSE (A): Acute Myocardial Infarction					
TIME INTERVAL BETWEEN ONSET AND DEATH					
Days					
107 DEATH REPORTED TO CORONER					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
108 DEATH REPORTED TO CORONER					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
109 SHOUP 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 RELATED TO 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 (DECEASED ATTENDED SINCE DECEASED LAST BEEN ALIVE MM/DD/CCYY)					
12/01/1994 12/02/1995					
115 SIGNATURE AND TITLE OF CERTIFIER					
Albert K. Gal M.D.					
116 LICENSE NO.					
G 57976					
117 DATE MM/DD/CCYY					
12/11/1995					
118 TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS & ZIP					
92691					
119 TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS & ZIP					
Albert K. Gerald, M.D., 27700 Med. Ctr. Rd. Mission Viejo Ca.					
120 INJURY AT WORK					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
121 INJURY DATE MM/DD/CCYY					
-					
122 HOUR					
-					
123 PLACE OF INJURY					
-					
124 DESCRIBE HOW INJURY OCCURRED (EVENTS WHICH PRECEDED IN INJURY)					
-					
125 MANNER OF DEATH					
<input type="checkbox"/> NATURAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE					
<input type="checkbox"/> ACCIDENT <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED					
126 LOCATION (STREET AND NUMBER OR LOCATION AND CITY AND ZIP CODE)					
-					
127 SIGNATURE OF CORONER OR DEPUTY CORONER					
[Signature]					
128 DATE MM/DD/CCYY					
-					
129 TYPED NAME, TITLE OF CORONER OR DEPUTY CORONER					
-					
STATE REGISTRAR					
A B C					
88726					

#3 X5 Card
No Real Existence, Mds.

97006906

97 FEB -5 AM 9:17

LAKE COUNTY
FILED FOR RECORD

RECORDED
MORRIS W. CARTER

900
Ya
#17918

FILED

JAN 31 1997

SAM ORLICH

INDITOR LAKE COUNTY



This is a true and exact reproduction of the document officially registered and placed on file in the office of the VITAL RECORDS SECTION, ORANGE COUNTY HEALTH CARE AGENCY.

12/13/1995
[Signature]
HUGH F. STALLWORTH, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

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

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE