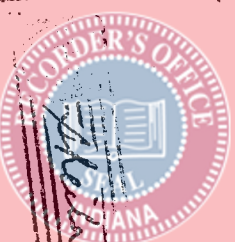


JAN 22 1998

CITY OF CHICAGO
DEPARTMENT OF PUBLIC HEALTH

SHEILA LYNE, RSM, LOCAL REGISTRAR OF VITAL STATISTICS OF THE CITY OF CHICAGO, DO HEREBY CERTIFY THAT I AM THE KEEPER OF THE RECORDS OF BIRTHS, STILLBIRTHS AND DEATHS FOR THE CITY OF CHICAGO BY VIRTUE OF THE LAWS OF THE STATE OF ILLINOIS AND THE ORDINANCES OF THE CITY OF CHICAGO, THAT THE ACCOMPANYING CERTIFICATE ON THIS SHEET IS A TRUE COPY OF A RECORD KEPT BY ME IN PURSUANCE OF SAID LAWS AND ORDINANCES.



Sheila Lyne
LOCAL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DISTRICT NO. REGISTERED NUMBER DECEASED-NAME FIRST MIDDLE LAST SEX DATE OF BIRTH (MONTH, DAY, YEAR) DATE OF DEATH (MONTH, DAY, YEAR)

1. MICHAEL W. MALONE 2. MALE 3. JANUARY 20, 1998

CITY, TOWN, TWP. OR ROAD DISTRICT NUMBER COUNTY OF DEATH

4. CHICAGO COOK HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) HOSPICE

5a. AGE-LAST BIRTHDAY (YRS) 5b. 81 5c. HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) 5d. 81 5e. HOSPITAL OR OTHER INSTITUTION-NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) 5f. HOSPICE

6a. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) CHICAGO, Illinois 6b. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) Married 6c. DECEASED (VERMINUS ARMED FORCES) (YES/NO) NO

7. Chicago, Illinois 8a. MARIED 8b. Married 8c. DECEASED (VERMINUS ARMED FORCES) (YES/NO) NO

9. Cook 10. 318-10-8046 11a. Stationary Eng. 11b. Stationary Eng. 11c. Cook

10. 318-10-8046 11a. Stationary Eng. 11b. Stationary Eng. 11c. Cook

12. Education (Specify Only Highest Grade Completed) 12. 12 13. Inside City (Yes/No) 13c. Yes

13a. 6445 South Kilpatrick 13b. Chicago 13c. Yes 13d. Cook

14. Carmella Papone 14b. No 14c. No 14d. No

15. Informant's Name (Type or Print) Anthony Malone 16. Mailing Address (Street and No. or R.F.D. City or Town, State, ZIP) 6445 So. Kilpatrick Chicago, Illinois

17a. Florence Malone 17b. Wife 17c. Carmella Papone

18. PART I Immediate Cause (Final disease or condition resulting in death) (a) BONE METASTASIS OF PROSTATE (b) CARCINOMA OF MELLITUS (c) DIARRHEA

19. Conditions if any which give rise to immediate cause (a) (b) (c)

20a. Date of Operation (If Any) 20b. Major Findings of Operation 20c. Was Coroner or Medical Examiner Notified? (Yes/No) NO 20d. Date Signed (Month, Day, Year) 1-21-98

21. Date of Operation (If Any) 21b. Major Findings of Operation 21c. Was Coroner or Medical Examiner Notified? (Yes/No) NO 21d. Date Signed (Month, Day, Year) 1-21-98

22. Name and Address of Certifier (Type or Print) JAYANTIBHAI K. PATEL, M.D. 22a. Name and Address of Certifier (Type or Print) JAYANTIBHAI K. PATEL, M.D. 22b. Illinois License Number 036 051749

23. Name of Attending Physician (If Other Than Certifier) 23a. Name of Attending Physician (If Other Than Certifier) 23b. Illinois License Number

24. Name of Crematory (If Any) 24a. Name of Crematory (If Any) 24b. Name of Crematory (If Any) 24c. Name of Crematory (If Any) 24d. Name of Crematory (If Any)

25. Name of Funeral Home 25a. Name of Funeral Home 25b. Name of Funeral Home 25c. Name of Funeral Home

26. Local Registrar's Signature (Type or Print) Sheila Lyne 26a. Local Registrar's Signature (Type or Print) Sheila Lyne

THIS CERTIFIED COPY VALID WHEN MULTICOLOR OR SIGNATURE SEAL IS AFFIXED.

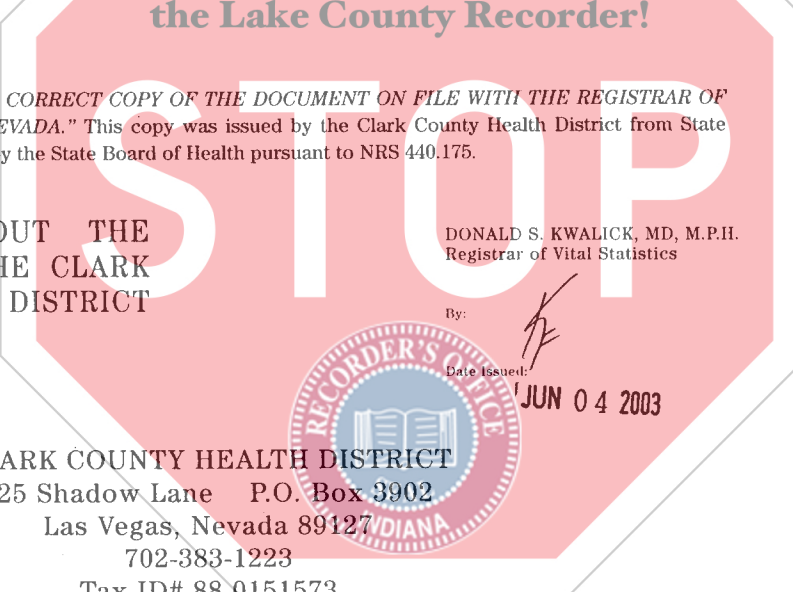
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STATE OF NEVADA DEPARTMENT OF HUMAN RESOURCES
 DIVISION OF HEALTH — SECTION OF VITAL STATISTICS
CERTIFICATE OF DEATH

LOCAL FILE NUMBER		STATE FILE NUMBER	
1. DECEASED—NAME First Middle Last Florence N MALONE		2. DATE OF DEATH (Month, Day, Year) May 26, 2003	
3b. CITY, TOWN OR LOCATION OF DEATH Boulder City		3a. COUNTY OF DEATH Clark	
3c. HOSPITAL OR OTHER INSTITUTION—Name (If not either, give street and number) 505 Greenbriar Place		4. SEX Female	
RACE—(e.g., White, Black, American Indian, etc.) (Specify) White		DATE OF BIRTH (Mo., Day, Yr.) December 30, 1918	
7a. AGE—Last (Birthday, Y/years) 84		7b. UNDER 1 YEAR MOS : DAYS 7c. UNDER 1 DAY HOURS : MINS	
8. Was Decedent of Hispanic Origin? Specify <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, specify Mexican, Cuban, Puerto Rican, etc.		11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, WIDOWED	
9a. STATE OF BIRTH (If not U.S.A., name country) Illinois		10. Decedent's Education. Specify highest grade completed. 8	
9b. CITIZEN OF WHAT COUNTRY USA		12. SURVIVING SPOUSE (If wife, give maiden name)	
13. SOCIAL SECURITY NUMBER 351-01-5854		14. KIND OF BUSINESS OR INDUSTRY Homemaker	
14a. USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even if Retired) Housewife		14b. KIND OF BUSINESS OR INDUSTRY	
15a. RESIDENCE—STATE Oregon		15b. COUNTY Multnomah	
15c. CITY, TOWN, OR LOCATION Portland		15d. STREET AND NUMBER 12699 S E Hearld	
15e. INSIDE CITY LIMITS (Specify Yes or No) Yes		16. FATHER—NAME First Middle Last	
17. MOTHER—MAIDEN NAME First Middle Last		18. INFORMANT—NAME (Type or Print) Susan Musgrove - Daughter	
18b. MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) 12699 S E Hearld Portland Oregon 97236		19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) Crementation	
19b. CEMETERY OR CREMATORY—NAME Sunrise Crementation & Burial Society		19c. LOCATION City or Town State Henderson, Nevada	
20a. FUNERAL DIRECTOR—SIGNATURE (Or Print Name) <i>[Signature]</i>		20b. FUNERAL DIRECTOR LICENSE NUMBER 605	
20c. NAME AND ADDRESS OF FACILITY Sunrise Crementation & Burial Society		20d. ADDRESS 745 W. Sunset Rd. #5, Henderson, Nevada 89015	
21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) <i>[Signature]</i>		22a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) and manner stated. (Signature and Title) <i>[Signature]</i>	
21b. DATE SIGNED (Mo., Day, Yr.) 5/27/03		21c. HOUR OF DEATH 0953	
21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		22b. DATE SIGNED (Mo., Day, Yr.)	
21e. HOUR OF DEATH		22c. HOUR OF DEATH	
22d. ON		22e. AT	
23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER). (Type or Print) Karen Cross MD 4141 Swenson St Las Vegas Nevada 89119		23b. LICENSE NUMBER 6052	
24a. REGISTRAR (Signature) <i>[Signature]</i>		24b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) JUN 03 2003	
24c. DEATH DUE TO COMMUNICABLE DISEASE		24d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) PART I (a) colore cancer		Interval between onset and death	
(b) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death	
(c) DUE TO, OR AS A CONSEQUENCE OF:		Interval between onset and death	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not resulting in the underlying cause given in Part I.		26. AUTOPSY (Specify Yes or No) No	
27. WAS CASE REFERRED TO CORONER (Specify Yes or No) Yes		28. ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 28a.	
28b. DATE OF INJURY (Mo., Day, Yr.)		28c. HOUR OF INJURY	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION		28g. STREET OR R.F.D. No.	
28h. CITY OR TOWN		28i. STATE	

STATE REGISTRAR **No. 238760**

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STOP

"CERTIFIED TO BE A TRUE AND CORRECT COPY OF THE DOCUMENT ON FILE WITH THE REGISTRAR OF VITAL STATISTICS, STATE OF NEVADA." This copy was issued by the Clark County Health District from State certified documents as authorized by the State Board of Health pursuant to NRS 440.175.

NOT VALID WITHOUT THE RAISED SEAL OF THE CLARK COUNTY HEALTH DISTRICT

DONALD S. KWALICK, MD, M.P.H.
Registrar of Vital Statistics

By: *[Signature]*
Date Issued: **JUN 04 2003**

CLARK COUNTY HEALTH DISTRICT
625 Shadow Lane P.O. Box 3902
Las Vegas, Nevada 89127
702-383-1223
Tax ID# 88-0151573

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