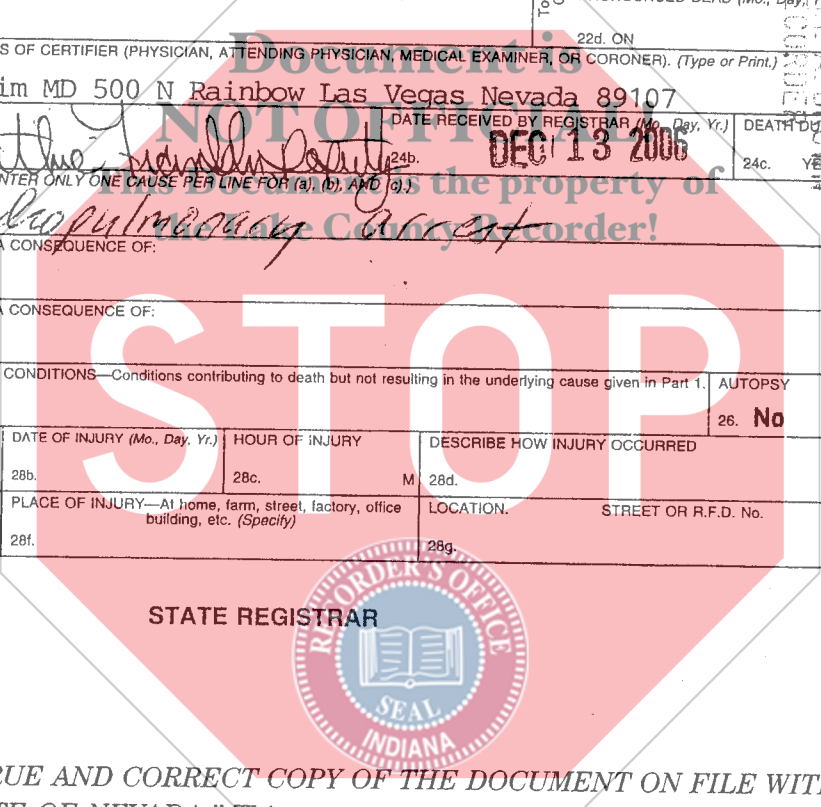


**DIVISION OF HEALTH — SECTION OF VITAL STATISTICS
CERTIFICATE OF DEATH**

TYPE OR PRINT IN PERMANENT BLACK INK	LOCAL FILE NUMBER		DECEASED—NAME First Middle Last		DATE OF DEATH (Month, Day, Year)		STATE FILE NUMBER	
	1. Kazimierz F. RYBACKI		2. December 9, 2006		3a. Clark			
DECEDENT	CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION—Name (If not either, give street and number)		If Hosp. or Inst. indicate DOA, OP/Emer: Rm. Inpatient (Specify)		SEX	
	3b. Las Vegas		3c. Summerlin Hospital Medical Center		3e. Emergency Room		4. Male	
IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS	RACE—(e.g., White, Black, American Indian, etc.) (Specify)		Was Decedent of Hispanic Origin? Specify <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, specify Mexican, Cuban, Puerto Rican, etc.		AGE—Last Birthday (Years)		DATE OF BIRTH (Mo., Day, Yr.)	
	5. White		6.		7a. 74		8. Jul 11, 1932	
PARENTS	STATE OF BIRTH (If not U.S.A., name country)		CITIZEN OF WHAT COUNTRY		Decedent's Education. Specify highest grade completed.		MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
	9a. Poland		9b. U.S.A.		10. 16		11. Married	
DISPOSITION	SOCIAL SECURITY NUMBER		USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even if Retired)		KIND OF BUSINESS OR INDUSTRY		SURVIVING SPOUSE (If wife, give maiden name)	
	13. [REDACTED]		14a. Machinist / Retired		14b. Manufacturing		15. Krystyna Strzeszewska	
CERTIFIER	RESIDENCE—STATE		COUNTY		CITY, TOWN, OR LOCATION		STREET AND NUMBER	
	15a. Indiana		15b. Lake		15c. Crown Point		15d. 1844 Fir	
CAUSE OF DEATH	FATHER—NAME First Middle Last		MOTHER—MAIDEN NAME First Middle Last		INFORMANT—NAME (Type or Print)		MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip)	
	16. Franciszek Rybacki		17. Leokadia Rzepczynska		18a. Krystyna Rybacki - Wife		18b. 1844 Fir Ct., Crown Point, Indiana 46307	
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST	BURIAL, CREMATION, REMOVAL, OTHER (Specify)		CEMETERY OR CREMATORY—NAME		LOCATION City or Town State			
	19a. Burial		19b. Palm Memorial Park - Northwest		19c. Las Vegas, Nevada			
To be completed by Certifying Physician	FUNERAL DIRECTOR—SIGNATURE (Or Person Acting as Supt.)		FUNERAL DIRECTOR LICENSE NUMBER		NAME AND ADDRESS OF FACILITY			
	20a. [Signature]		20b. 50		20c. 7400 W. Cheyenne Rd., Las Vegas, Nevada 89129			
To be completed by Coroner's Office	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)		DATE SIGNED (Mo., Day, Yr.)		HOUR OF DEATH		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)	
	21b. [Signature]		21c. 12/12/06		21d. 1:12 PM		22b. [Signature]	
To be completed by Registrar	NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER). (Type or Print)		LICENSE NUMBER		23a. John Kim MD 500 N Rainbow Las Vegas Nevada 89107		23b. 10539	
	23a. [Signature]		23b. [Signature]		23c. [Signature]		23d. [Signature]	
PART I	24a. (Signature)		DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)		DEATH DUE TO COMMUNICABLE DISEASE		24c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	24a. [Signature]		24b. DEC 13 2006		24c. [Signature]		24d. [Signature]	
PART II	25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)		(a) Cardiovascular arrest		(b) Due to, or as a consequence of:		Interval between onset and death	
	(a) Due to, or as a consequence of:		(b) Due to, or as a consequence of:		(c) Other significant conditions—Conditions contributing to death but not resulting in the underlying cause given in Part I.		AUTOPSY (Specify Yes or No)	
26. No		27. Yes [Signature]		DATE OF INJURY (Mo., Day, Yr.)		HOUR OF INJURY		
28a. [Signature]		28b. [Signature]		28c. [Signature]		28d. [Signature]		
28e. [Signature]		28f. [Signature]		28g. [Signature]		28h. [Signature]		



STATE REGISTRAR

No. 349869



"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: [Signature]

DEC 14 2006

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

FILED

SEP 17 2009

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

TICOR TITLE INC.
920096579

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