

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

	LOCAL FILE NUMBER	DECEASED—NAME First Middle Last 1. <b>James Anthony CULP</b>	DATE OF DEATH (Month, Day, Year) 2. <b>July 20, 2003</b>	STATE FILE NUMBER 3a. <b>Clark</b>
TYPE OR PRINT IN PERMANENT BLACK INK	CITY, TOWN OR LOCATION OF DEATH 3b. <b>Henderson</b>		HOSPITAL OR OTHER INSTITUTION—Name (If not either, give street and number) 3c. <b>St. Rose Dominican Hospital - Siena Campus</b>	
	RACE—(e.g., White, Black, American Indian, etc.) (Specify) 5. <b>White</b>		Was Decedent of Hispanic Origin? Specify <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, specify Mexican, Cuban, Puerto Rican, etc. 6. <b>X</b>	
IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS	STATE OF BIRTH (If not U.S.A., name country) 9a. <b>Indiana</b>		CITIZEN OF WHAT COUNTRY 9b. <b>U.S.A.</b>	
	SOCIAL SECURITY NUMBER 13. <b>309-34-9256</b>		USUAL OCCUPATION (Give Kind of Work Done During Most of Working Life, Even if Retired) 14a. <b>Director/Park Designer / Retired</b>	
DECEASED	RESIDENCE—STATE 15a. <b>Indiana</b>		CITY, TOWN, OR LOCATION 15c. <b>Hobart</b>	
	COUNTY 15b. <b>Lake</b>		STREET AND NUMBER 15d. <b>504 N. Washington</b>	
PARENTS	FATHER—NAME First Middle Last 16. <b>James Henry Culp</b>		MOTHER—MAIDEN NAME First Middle Last 17. <b>Helen Hutton</b>	
	INFORMANT—NAME (Type or Print) 18a. <b>Shelly Bradford Culp - Wife</b>		MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) 18b. <b>504 N. Washington Street, Hobart, Indiana 46342</b>	
DISPOSITION	BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a. <b>Cremation</b>		CEMETERY OR CREMATORY—NAME 19b. <b>Palm Crematory</b>	
	FUNERAL DIRECTOR SIGNATURE (Or Person Acting as such) 20a. <i>[Signature]</i>		NAME AND ADDRESS OF FACILITY 20c. <b>Palm Mortuary - Eastern 7600 S. Eastern Ave., Las Vegas, Nevada 89123</b>	
CERTIFIER	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>	
	DATE SIGNED (Mo., Day, Yr.) 21b. <b>7/22/03</b>		DATE SIGNED (Mo., Day, Yr.) 22b. <b>7/22/03</b>	
CAUSE OF DEATH	HOUR OF DEATH 21c. <b>10:30 PM</b>		HOUR OF DEATH 22c. <b>10:30 PM</b>	
	NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print) 21d. <b>Tony Gumina MD 2510 Wigwam Pkwy. Henderson Nevada 89074</b>		PRONOUNCED DEAD (Mo., Day, Yr.) 22d. <b>ON</b>	
CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST	23a. <b>Tony Gumina MD 2510 Wigwam Pkwy. Henderson Nevada 89074</b>		LICENSE NUMBER 23b. <b>9899</b>	
	REGISTRAR 24a. <i>[Signature]</i>		DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) 24b. <b>JUL 23 2003</b>	
CAUSE OF DEATH	25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) PART I (a) <b>RESPIRATORY ARREST</b>		DEATH DUE TO COMMUNICABLE DISEASE 24c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	(b) <b>CVA</b>		Interval between onset and death	
CAUSE OF DEATH	(c) <b>AFIB</b>		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. <b>DEBILITY, PFT</b>		AUTOPSY (Specify Yes or No) 26. <b>No</b>	
CAUSE OF DEATH	ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 28a.		DATE OF INJURY (Mo., Day, Yr.) 28b.	
	INJURY AT WORK (Specify Yes or No) 28e.		HOUR OF INJURY 28c.	
CAUSE OF DEATH	PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify) 28f.		DESCRIBE HOW INJURY OCCURRED 28d.	
	LOCATION 28g.		STREET OR R.F.D. No. CITY OR TOWN STATE	

H/5-09-30-255-004-000-018



"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]*