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CERTIFICATE OF DEATH

STATE OF CALIFORNIA — DEPARTMENT OF HEALTH
OFFICE OF THE STATE REGISTRAR OF VITAL STATISTICS

STATE FILE NUMBER | LOCAL REGISTRATION DISTRICT AND CERTIFICATE NUMBER

DECEDENT PERSONAL DATA

1a. NAME OF DECEASED—FIRST NAME	1b. MIDDLE NAME	1c. LAST NAME	2a. DATE OF DEATH—MONTH DAY YEAR	2b. HOUR
Johnathan	Iryen	MC CANCE	JANUARY 29, 1976	9:00 A. M

3. SEX	4. COLOR OR RACE	5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	6. DATE OF BIRTH	7. AGE (LAST BIRTHDAY)	8. IF UNDER 1 YEAR	9. IF UNDER 24 HOURS
Male	Caucasian	Nebraska	July 16, 1894	81 YEARS		

8. NAME AND BIRTHPLACE OF FATHER	9. MAIDEN NAME AND BIRTHPLACE OF MOTHER
John D. McCance, Illinois	Irene Kirkpatrick, Iowa

10. CITIZEN OF WHAT COUNTRY	11. SOCIAL SECURITY NUMBER	12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY)	13. NAME OF SURVIVING SPOUSE (IF WIFE, ENTER MAIDEN NAME)
USA	564-10-7580	Married	Grace Brown

14. LAST OCCUPATION	15. NUMBER OF YEARS IN THIS OCCUPATION	16. NAME OF LAST EMPLOYING COMPANY OR FIRM (IF SELF-EMPLOYED, SO STATE)	17. KIND OF INDUSTRY OR BUSINESS
Machinist	20	Kaiser Steel Corp.	Steel

PLACE OF DEATH

18a. PLACE OF DEATH—NAME OF HOSPITAL OR OTHER IN PATIENT FACILITY	18b. STREET ADDRESS—(STREET AND NUMBER OR LOCATION)	18c. INSIDE CITY CORPORATE LIMITS (SPECIFY YES OR NO)
KAISER FOUNDATION HOSPITAL	9961 SIERRA AVENUE	YES

18d. CITY OR TOWN	18e. COUNTY	18f. RESIDENCE OF DECEASED—STATE OF FOREIGN COUNTRY	18g. LENGTH OF STAY IN CALIFORNIA
FONTANA	SAN BERNARDINO	30 YEARS	45 YEARS

USUAL RESIDENCE (IF DEATH OCCURRED IN INSTITUTION, ENTER RESIDENCE BEFORE ADMISSION)

19a. USUAL RESIDENCE—STREET ADDRESS (STREET AND NUMBER OR LOCATION)	19b. INSIDE CITY CORPORATE LIMITS (SPECIFY YES OR NO)	20. NAME AND MAILING ADDRESS OF INFORMANT
8401 Cottonwood	no	Grace McCance, spouse

19c. CITY OR TOWN	19d. COUNTY	19e. STATE	
Fontana	San Bernardino	California	Same

PHYSICIAN'S OR CORONER'S CERTIFICATION

21a. CORONER: I HEREBY CERTIFY THAT DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED ABOVE FROM THE CAUSES STATED BELOW AND THAT I HAVE HELD ON THE REMAINS OF DECEASED AS REQUIRED BY LAW. (SIGNATURE AND OFFICIAL TITLE)	21b. PHYSICIAN: I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM THE CAUSES STATED BELOW AND THAT DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED ABOVE. (SIGNATURE AND OFFICIAL TITLE)	21c. PHYSICIAN OR CORONER—SIGNATURE AND MAILING ADDRESS (STREET OR P.O. BOX, CITY OR TOWN, STATE)	21d. DATE SIGNED
	FROM (ENTER MONTH, DAY, YEAR) JAN 1975 TO (ENTER MONTH, DAY, YEAR) 1-29-76 AND (ENTER MONTH, DAY, YEAR) 1-29-76	▶ Anthony B. Radcliffe M.D.	1-29-76
		21e. ADDRESS 9961 SIERRA, FONTANA CALIF	21f. LICENSE NUMBER G 22620

FUNERAL DIRECTOR AND LOCAL REGISTRAR

22a. SPECIFY BURIAL, ENTOMBMENT OR CREMATION	22b. DATE	23. NAME OF CEMETERY OR CREMATORY	24. EMBALMER—SIGNATURE AND LICENSE NUMBER OF EMBALMER
Burial	2-2-76	Green Acres Mem. Gardens	Larry K. Schmidt 6419

25. NAME OF FUNERAL DIRECTOR (OR PERSON ACTING AS SUCH)	26. IF NOT CERTIFIED BY CORONER, WAS THIS DEATH REPORTED TO CORONER? (SPECIFY YES OR NO)	27. LOCAL REGISTRAR—SIGNATURE	28. DATE RECEIVED BY LOCAL REGISTRAR
Ingold Chapel, Fontana, Ca.	no	▶ L E Mahoney, MD MPH	1-30-76

CAUSE OF DEATH (MEDICAL AND HEALTH DATA)

29. PART I. DEATH WAS CAUSED BY — ENTER ONLY ONE CAUSE PER LINE FOR A, B AND C.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	Pneumonia	1 wk
DUE TO, OR AS A CONSEQUENCE OF (B)	2° to multiple cerebral vascular accidents	6 mos.
DUE TO, OR AS A CONSEQUENCE OF (C)	Arteriosclerosis	4 yrs

CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE (A), STATING THE UNDERLYING CAUSE LAST.

30. PART II. OTHER SIGNIFICANT CONDITIONS—CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TWO IMMEDIATE CAUSES GIVEN IN PART II

31. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 29 OR 30? (SPECIFY YES OR NO) IF YES, ENTER DATE OF OPERATION AND/OR PHYSICAL FINDINGS	32A. AUTOPSY? (SPECIFY YES OR NO)	32B. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (SPECIFY YES OR NO)
YES/OPERATION	NO	----------

INJURY INFORMATION

33. SPECIFY ACCIDENT, SUICIDE OR HOMICIDE	34. PLACE OF INJURY (SPECIFY HOME, FARM, FACTORY, OFFICE BUILDING, ETC.)	35. INJURY AT WORK (SPECIFY YES OR NO)	36A. DATE OF INJURY—MONTH DAY YEAR	36B. HOUR
				M

37A. PLACE OF INJURY (STREET AND NUMBER OR LOCATION AND CITY OR TOWN)	37B. DISTANCE FROM CITY LIMITS OF INJURY TO USUAL RESIDENCE, ITEM 19	38. WAS INJURY DUE TO TOXIC CHEMICAL? (SPECIFY YES OR NO)	39. WAS INJURY DUE TO ALCOHOL? (SPECIFY YES OR NO)
	MILES		

40. DESCRIBE HOW INJURY OCCURRED (ENTER SEQUENCE OF EVENTS WHICH RESULTED IN INJURY. NATURE OF INJURY SHOULD BE ENTERED IN ITEM 29.)

12-2-2

STATE REGISTRAR

A.	B.	C.	D.	E.	F.

This must be in red to be a "CERTIFIED COPY"

File! nope need record collect! -

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF A CERTIFICATE ON FILE IN THE SAN BERNARDINO COUNTY HEALTH DEPARTMENT, IF THE WORDS CERTIFIED COPY ARE IN RED.

Louis E. Mahoney, M.D., M.P.H.
DIRECTOR OF PUBLIC HEALTH

DEPARTMENT OF PUBLIC HEALTH — REGISTRAR OF VITAL STATISTICS — COUNTY OF SAN BERNARDINO

STATE OF OREGON; COUNTY OF KLAMATH; ss.

I hereby certify that the within instrument was received and filed for record on the 23rd day of AUGUST A.D., 19 76 at 2; 18 o'clock P M., and duly recorded in Vol M 76, of DEEDS on Page 13083.

INDEXED

FEE $ 3.00 D ✓ I ✓

WM. D. MILNE, County Clerk

By Hazel Bragg Deputy