

CERTIFICATE OF DEATH

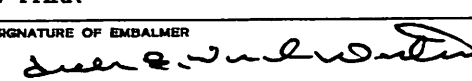
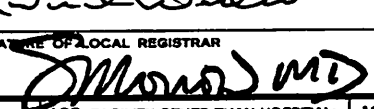
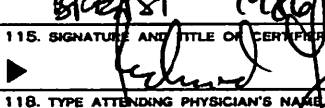
STATE OF CALIFORNIA

USE BLACK INK ONLY/NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV. 7/93)

3-94-41-000966

STATE FILE NUMBER

LOCAL REGISTRATION NUMBER

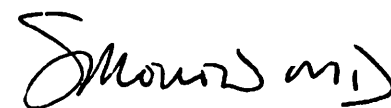
DECEDENT PERSONAL DATA	1. NAME OF DECEDENT—FIRST (GIVEN) AMELIA			2. MIDDLE M.			3. LAST (FAMILY) ESCOTO							
	4. DATE OF BIRTH MM/DD/CCYY 08/09/1926		5. AGE YRS. 67		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HOURS HOURS MINUTES		6. SEX F		7. DATE OF DEATH MM/DD/CCYY 03/11/1994		8. HOUR 1010	
	9. STATE OF BIRTH NM		10. SOCIAL SECURITY NO. 563-36-3782			11. MILITARY SERVICE 19__ TO 19__ <input checked="" type="checkbox"/> NONE			12. MARITAL STATUS MARRIED		13. EDUCATION —YEARS COMPLETED 12			
	14. RACE WHITE			15. HISPANIC—SPECIFY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			16. USUAL EMPLOYER SELF-EMPLOYED							
	17. OCCUPATION HOMEMAKER				18. KIND OF BUSINESS OWN HOME				19. YEARS IN OCCUPATION 47					
USUAL RESIDENCE	20. RESIDENCE—STREET AND NUMBER OR LOCATION 2432 LINCOLN ANNVUE													
	21. CITY BELMONT			22. COUNTY SAN MATEO			23. ZIP CODE 94002			24. YRS IN COUNTY 41		25. STATE OR FOREIGN COUNTRY CA		
INFORMANT	26. NAME, RELATIONSHIP PETER ESCOTO - SPOUSE						27. MAILING ADDRESS (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE, ZIP) 2432 LINCOLN AVENUE, BELMONT CA 94002							
	SPOUSE AND PARENT INFORMATION	28. NAME OF SURVIVING SPOUSE—FIRST PETER			29. MIDDLE RAMOS			30. LAST (MAIDEN NAME) ESCOTO						
31. NAME OF FATHER—FIRST EDWURDO			32. MIDDLE ---			33. LAST MUNGUIA			34. BIRTH STATE AZ					
35. NAME OF MOTHER—FIRST ELIGIA			36. MIDDLE ---			37. LAST (MAIDEN) TERRAZAS			38. BIRTH STATE MEXICO					
39. DATE MM/DD/CCYY 03/15/1994		40. PLACE OF FINAL DISPOSITION SKYLAWN MEMORIAL PARK												
FUNERAL DIRECTOR AND LOCAL REGISTRAR	41. TYPE OF DISPOSITION(S) BU			42. SIGNATURE OF EMBALMER 						43. LICENSE NO. 7904				
	44. NAME OF FUNERAL DIRECTOR DUGGAN'S CARLMONT CHAPEL			45. LICENSE NO. 1039		46. SIGNATURE OF LOCAL REGISTRAR 				47. DATE MM/DD/CCYY 03/14/1994				
PLACE OF DEATH	101. PLACE OF DEATH MILLS HOSPITAL			102. IF HOSPITAL SPECIFY ONE: <input checked="" type="checkbox"/> IP <input type="checkbox"/> ER/OP <input type="checkbox"/> DOA			103. FACILITY OTHER THAN HOSPITAL: <input type="checkbox"/> CONV. HOSP. <input type="checkbox"/> RES. <input type="checkbox"/> OTHER			104. COUNTY SAN MATEO				
	105. STREET ADDRESS—STREET AND NUMBER OR LOCATION 100 SOUTH SAN MATEO DRIVE								106. CITY SAN MATEO					
CAUSE OF DEATH	107. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR A, B, C, AND D)							TIME INTERVAL BETWEEN ONSET AND DEATH 8 YEARS		108. DEATH REPORTED TO CORONER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO REFERRAL NUMBER				
	IMMEDIATE CAUSE (A) METASTATIC BREAST CANCER													
	DUE TO (B)									109. BIOPSY PERFORMED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
	DUE TO (C)									110. AUTOPSY PERFORMED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
	DUE TO (D)									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														
113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? IF YES, LIST TYPE OF OPERATION AND DATE. MASTECTOMY RIGHT BREAST 1986														
PHYSICIAN'S CERTIFICATION	114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED. DECEDENT ATTENDED SINCE MM/DD/CCYY 4 29 92 DECEDENT LAST SEEN ALIVE MM/DD/CCYY 3 11 94			115. SIGNATURE AND TITLE OF CERTIFIER  M.D.			116. LICENSE NO. A53170		117. DATE MM/DD/CCYY 3/14/94					
	118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS + ZIP Richard Young, M.D., 1 Baywood Dr., San Mateo, CA													
CORONER'S USE ONLY	I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE AND PLACE STATED FROM THE CAUSES STATED.			120. INJURY AT WORK <input type="checkbox"/> YES <input type="checkbox"/> NO		121. INJURY DATE MM/DD/CCYY		122. HOUR		123. PLACE OF INJURY				
	119. 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			124. DESCRIBE HOW INJURY OCCURRED (EVENTS WHICH RESULTED IN INJURY)										
	125. LOCATION (STREET AND NUMBER OR LOCATION AND CITY AND ZIP CODE)													
126. SIGNATURE OF CORONER OR DEPUTY CORONER				127. DATE MM/DD/CCYY				128. TYPED NAME, TITLE OF CORONER OR DEPUTY CORONER						

STATE A B C D E F G H FAX AUTH. # CENSUS TRACT

**SAN MATEO COUNTY
DEPARTMENT OF HEALTH SERVICES**

**225 West 37th Avenue
San Mateo, California 94403**

This is to certify that, if bearing the raised department seal, this is a true copy of the document filed in this office.



**SCOTT MORROW, M.D.
Health Officer and Registrar**

MAR 14 1994

