

RECEIVED

JUL 07 2004

DEPARTMENT OF
OF COUNSEL WATER RESOURCES
WYNNE M. BLAKE

RANDALL, BLAKE & COX, P.A.

LAWYERS

1106 IDAHO STREET

P.O. Box 446

LEWISTON, ID 83501

(208) 743-1234

TELEFAX - (208) 743-1266

STEVE R. COX*
DAVID R. RISLEY*
SCOTT CHAPMAN*
KERRY A. WAGNER*
DERRICK A. ATER
* LICENSED IN IDAHO AND WASHINGTON

RUSSELL S. RANDALL
(1908-2004)

July 2, 2004

Idaho Department of Water Resources
P.O. Box 83720
Boise, ID 83707-9815

Attn: Carter Fritschle

RE: John W. Myers & Donna L. Myers Water Rights

Dear Mr. Fritschle:

Enclosed please find two Notice of Error Reply forms which Donna L. Myers has signed.

Would you please put the water rights in the name of Donna L. Myers. John W. Myers passed away May 25, 2003, a copy of his death certificate is enclosed.

Very truly yours,


STEVE R. COX *J*

SRC:fw
encs.

05/18/2004

RECEIVED

JUL 07 2004

DEPARTMENT OF
WATER RESOURCES

NOTICE OF ERROR
REPLY

Please type or print clearly, fill out this form completely and mail.

Return this reply form to IDWR by the deadline date printed below if you want IDWR to change your recommendation or you want to let IDWR know that you agree with its recommendation.

YOUR DEADLINE FOR RETURNING A NOTICE OF ERROR REPLY IS: July 15, 2004

Water right number: 86-11876

JOHN W MYERS
3462 ELKS DR
LEWISTON ID 83501

DONNA L. MYERS
3462 ELKS DR
LEWISTON ID 83501

1. Describe the portion of the proposed recommendation with which you disagree (e.g. priority date, period of use, source):

2. Describe the changes you wish to make in the proposed recommendation:

3. Give a brief explanation as to why you disagree with these portions:

X I AGREE with this proposed recommendation: no changes need to be made.

DATE: 7-1-2004

SIGNATURE:

Donna L. Myers

Please print your name:

Donna L. Myers

PH# 208 798-8561

IDWR Regional Office, 1910 Northwest Blvd, Suite 210, Coeur D' Alene, ID 83814, 2087691450

STATE OF IDAHO
IDAHO DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF HEALTH POLICY AND VITAL STATISTICS

State of Idaho

CERTIFICATE OF DEATH

STATE FILE NO.

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THE DEPARTMENT OF HEALTH AND WELFARE, SHALL BE USED AS PROOF OF EVIDENCE OF THE DEATH UNDER 100-241.00 AND 100-17.4, 100-2.00 CODE

Local Reg. No. 183

TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN FOR INSTRUCTIONS SEE HANDBOOKS PART I-EE (IN FORM) DISPOSITION PLACE OF DEATH DATE OF DEATH CAUSE OF DEATH	CERTIFIER: Complete Within 72 Hours of Death	MORTICIAN: Complete/Vetify and File Within 5 Days of Death	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)</td> <td colspan="2">2. SEX</td> <td colspan="2">3. SOCIAL SECURITY NUMBER</td> </tr> <tr> <td colspan="2">JOHN W. MYERS</td> <td colspan="2">Male</td> <td colspan="2"></td> </tr> <tr> <td colspan="2">4a. AGE - Last Birthday</td> <td colspan="2">4c. UNDER 1 YEAR</td> <td colspan="2">4e. UNDER 1 DAY</td> </tr> <tr> <td colspan="2">73 (Years)</td> <td colspan="2">Months _____ Days _____</td> <td colspan="2">Hours _____ Minutes _____</td> </tr> <tr> <td colspan="4">5. DATE OF BIRTH (Mo/Day/Yr)</td> <td colspan="2">6. 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PART I. Enter the chain of events -- diseases, injuries, or complications -- that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT abbreviate. Enter only one cause on a line.																																																																																																																																																																																																																																																																																																																																													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Rectal carcinoma with liver metastases</i>																																																																																																																																																																																																																																																																																																																																													
Sequitely list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE LAST (Disease or injury that initiated the events resulting in death).																																																																																																																																																																																																																																																																																																																																													
b. DUE TO for as a consequence of: c. DUE TO for as a consequence of: d. DUE TO for as a consequence of:																																																																																																																																																																																																																																																																																																																																													
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I																																																																																																																																																																																																																																																																																																																																													
<i>Type 1 diabetes, IHD</i>																																																																																																																																																																																																																																																																																																																																													
29. DID THE DECEDENT CONTRIBUTE TO DEATH?		30. IF FEMALE (Aged 10-84):		31. MANNER OF DEATH																																																																																																																																																																																																																																																																																																																																									
☐ Yes ☐ Probably ☒ No ☐ Unknown		☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death		☒ Natural ☐ Horrible ☐ Accident ☐ Pending investigation ☐ Suicide ☐ Could not be determined																																																																																																																																																																																																																																																																																																																																									
32. DATE OF INJURY (Mo/Day/Yr) (Spell month)		33. TIME OF INJURY		34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)																																																																																																																																																																																																																																																																																																																																									
		(24hr)																																																																																																																																																																																																																																																																																																																																											
35. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____																																																																																																																																																																																																																																																																																																																																													
Street and Number or Location _____ Apartment Number _____																																																																																																																																																																																																																																																																																																																																													
37. DESCRIBE HOW INJURY OCCURRED. IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable																																																																																																																																																																																																																																																																																																																																													
TRANSPORTATION: 38a. WAS DECEDENT: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____																																																																																																																																																																																																																																																																																																																																													
38b. WHAT SAFETY DEVICES(S) DID DECEDENT USE/EMPLOY? ☐ Seat belt ☐ Child safety seat ☐ Helmet ☐ Air bag ☐ None ☐ Unknown																																																																																																																																																																																																																																																																																																																																													
39a. CERTIFIER (Check only one, based on official capacity for this certificate)				39b. LICENSE NUMBER																																																																																																																																																																																																																																																																																																																																									
☒ PHYSICIAN - To the best of my knowledge, death occurred at the time, date, and place, and due to the natural cause(s)/manner stated. ☐ CORONER - On the basis of examination and/or transportation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				M-6680																																																																																																																																																																																																																																																																																																																																									
Signature and Title of Certifier: <i>[Signature]</i>				30b. DATE SIGNED																																																																																																																																																																																																																																																																																																																																									
* 39d. NAME, ADDRESS, AND ZIP CODE OF DECEDENT (Type or print)				MM/DD/YYYY																																																																																																																																																																																																																																																																																																																																									
Donald J. Greggain, M.D., 1271 Highland Avenue, Clarkston, Washington 99403				3/27/03																																																																																																																																																																																																																																																																																																																																									
40a. CORONER'S SUBSEQUENT SIGNATURE IF NECESSARY: The coroner's signature in this item supersedes that of the physician, and the coroner becomes the certifier of record.				40b. DATE SIGNED																																																																																																																																																																																																																																																																																																																																									
I have reviewed and if necessary amended the medical section				MM/DD/YYYY																																																																																																																																																																																																																																																																																																																																									
41a. CORONER'S SIGNATURE				41b. DATE SIGNED																																																																																																																																																																																																																																																																																																																																									
<i>Karen L Rugg</i>				05/28/2003																																																																																																																																																																																																																																																																																																																																									
				MM/DD/YYYY																																																																																																																																																																																																																																																																																																																																									

This is a true and correct reproduction of the document officially registered and placed on file with the IDAHO BUREAU OF HEALTH POLICY AND VITAL STATISTICS.

DATE ISSUED: May 28, 2003

This copy is not valid unless prepared on engraved border displaying state seal and signature of the Registrar.

JANE S. SMITH
STATE REGISTRAR

