

RECEIVED

APR 12 2005

**STATE OF IDAHO**  
**DEPARTMENT OF WATER RESOURCES**  
**NOTICE OF CHANGE IN WATER RIGHT OWNERSHIP**

Please print or type. Attach pages with additional information. Instructions are included at the end of this form.  
 Incomplete forms will be returned.

Department of Water Resources  
 Eastern Region

1. Please list the water right number(s) and/or adjudication claim number(s) (if any) for each water right to be changed. List just the adjudication claim number if there is no corresponding water right record on file with the department. Indicate, by checking in the space provided (under the "split" heading), if the change in ownership is limited to a portion of a water right in which case division of the existing water right or adjudication claim record will be required.

| Water<br>Right No(s). | Adjudication<br>Claim No(s). | Split | Water<br>Right No(s). | Adjudication<br>Claim No(s). | Split |
|-----------------------|------------------------------|-------|-----------------------|------------------------------|-------|
| NCAP - A35-07621      |                              |       |                       |                              |       |
| NCAP - A35-07618      |                              |       |                       |                              |       |
| (pd) - A35-11310      |                              |       |                       |                              |       |
|                       |                              |       |                       |                              |       |
|                       |                              |       |                       |                              |       |

2. The following **REQUIRED** information must be submitted with this form:

- A. The appropriate **FILING FEE**. See instructions for fee amounts.
- B. A copy of the most recent **DEED, TITLE POLICY, CONTRACT OF SALE** or other legal document indicating your ownership of the property and water right(s) or claim(s) in question, **WITH ATTACHED LEGAL DESCRIPTION**.
- C. Either of the following (if necessary to clarify division of water rights or other complex property descriptions):  
**PLAT OF PROPERTY** or **SURVEY MAP** clearly showing the location of the point(s) of diversion and place of use of your water right(s) and/or adjudication claim(s) (these are usually attached to your deed or on file with the county).

**OR**

If your water right(s) and/or adjudication claim(s) is for ten or more acres of irrigation, you must submit a USDA Farm Service Agency **AERIAL PHOTO** with the irrigated acres outlined and point(s) of diversion clearly marked. The AERIAL PHOTO should be submitted in place of the PLAT OF PROPERTY or SURVEY MAP.

3. Name and Address of Former Owner/Claimant(s) Juan A. Irigoyen  
1751 S. 2600 W. Aberdeen, Id. 83210
4. New Owner/Claimant(s) Lisa Irigoyen Funk  
 Name Connector (Check one): ☐ and, ☒ or, ☐ and/or N/A
- New Mailing Address 3853 Rast Rd.
- City, State and ZIP Code American Falls, Idaho 83211
- New Telephone Number 208 226-9976
5. Date you acquired the property July 2001 - when father passed away

6. **If the change in ownership affects the entire water right for each water right or adjudication claim number listed in item 1, THEN SKIP THIS ITEM AND GO TO ITEM 7.** If the change in ownership divides the water right(s) among multiple owners, you must describe, in detail, your portion of each water right after the change. Fill in the appropriate spaces in the box(es) below to describe your water right(s) after the change (one water right per box, you may copy this page as necessary). If your quantity of water is greater than a proportionate split, you must attach documentation to show justification for a larger amount. If you are not sure how to identify your portion of the original water right or adjudication claim records, please contact the nearest IDWR office for assistance.

| DESCRIPTION OF YOUR PORTION OF WATER RIGHT<br>(If the right(s) will not be split, skip this area and proceed to item 7) |                                                                            |                                                              |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------|
| Water Right and/or Adjudication Claim Number _____                                                                      |                                                                            |                                                              |
| Water Use                                                                                                               | Diversion Rate or Volume<br>(cubic feet per second or acre-feet per annum) | Description<br>(acres, number and type of stock, homes, etc) |
| Irrigation                                                                                                              | _____                                                                      | _____                                                        |
| Stock                                                                                                                   | _____                                                                      | _____                                                        |
| Domestic                                                                                                                | _____                                                                      | _____                                                        |
| Other _____                                                                                                             | _____                                                                      | _____                                                        |
| <b>Total</b>                                                                                                            | _____                                                                      | _____                                                        |

| DESCRIPTION OF YOUR PORTION OF WATER RIGHT<br>(If the right(s) will not be split, skip this area and proceed to item 7) |                                                                            |                                                              |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------|
| Water Right and/or Adjudication Claim Number _____                                                                      |                                                                            |                                                              |
| Water Use                                                                                                               | Diversion Rate or Volume<br>(cubic feet per second or acre-feet per annum) | Description<br>(acres, number and type of stock, homes, etc) |
| Irrigation                                                                                                              | _____                                                                      | _____                                                        |
| Stock                                                                                                                   | _____                                                                      | _____                                                        |
| Domestic                                                                                                                | _____                                                                      | _____                                                        |
| Other _____                                                                                                             | _____                                                                      | _____                                                        |
| <b>Total</b>                                                                                                            | _____                                                                      | _____                                                        |

7. Signature of New Owner(s) or Claimant(s) Lisa Briggner Funk  
(include title if applicable) \_\_\_\_\_

For Snake River Basin Adjudication Claims: Please attach a Notice of Appearance completed by your attorney, if you wish IDWR to correspond with him/her for all matters related to your claims.

**For Office Use Only**

Received by \_\_\_\_\_ Date \_\_\_\_\_ Fee \_\_\_\_\_  
 Receipted by \_\_\_\_\_ Date \_\_\_\_\_ Receipt No. \_\_\_\_\_  
 Processed by \_\_\_\_\_ AJ Date \_\_\_\_\_ WR \_\_\_\_\_ Date \_\_\_\_\_

# CERTIFICATION OF VITAL RECORD

## STATE OF IDAHO

IDAHO DEPARTMENT OF HEALTH AND WELFARE  
CENTER FOR VITAL STATISTICS AND HEALTH POLICY  
**CERTIFICATE OF DEATH**

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THIS SEAL, OF HEALTH & WELFARE RAISED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH UNDER IDAHO CODE 39-241(a) & 39-274

State File No. \_\_\_\_\_  
Local Reg. No. 108

|                                            |                                                                                                                                                                                                                     |                     |                                                                                                                                                  |                                                                                   |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>DECEDENT</b>                            | DECEDENT - NAME FIRST MIDDLE LAST                                                                                                                                                                                   |                     | SEX                                                                                                                                              | DATE OF DEATH (Month, Day, Year)                                                  |
|                                            | Juan Agustín Irigoyen                                                                                                                                                                                               |                     | Male                                                                                                                                             | June 15, 2001                                                                     |
|                                            | SOCIAL SECURITY NUMBER                                                                                                                                                                                              | AGE (Last Birthday) | DATE OF BIRTH (Month, Day, Year)                                                                                                                 | BIRTHPLACE (City and State or Foreign Country)                                    |
|                                            | 519-34-8305                                                                                                                                                                                                         | 75                  | Dec 22, 1925                                                                                                                                     | Spain                                                                             |
| <b>PARENTS</b>                             | FATHER - NAME                                                                                                                                                                                                       |                     | BIRTHPLACE                                                                                                                                       | MOTHER - FULL MAIDEN NAME                                                         |
|                                            | Martin Irigoyen                                                                                                                                                                                                     |                     | Spain                                                                                                                                            | Maria Echenique                                                                   |
|                                            | MARTIN STATUS - Married, Never Married, Widowed, Divorced (Specify)                                                                                                                                                 |                     | BIRTHPLACE                                                                                                                                       |                                                                                   |
|                                            | Widowed                                                                                                                                                                                                             |                     | Spain                                                                                                                                            |                                                                                   |
| <b>INFORMANT</b>                           | INFORMANT'S NAME (Type Print)                                                                                                                                                                                       |                     | MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                                                         |                                                                                   |
|                                            | Lisa Funk                                                                                                                                                                                                           |                     | 3853 Rast Rd., American Falls, ID 83211                                                                                                          |                                                                                   |
|                                            | METHOD OF DISPOSITION                                                                                                                                                                                               |                     | PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)                                                                               |                                                                                   |
|                                            | Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____                                   |                     | Aberdeen Cemetery                                                                                                                                |                                                                                   |
| <b>DISPOSITION</b>                         | SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH                                                                                                                                                      |                     | LICENSE NUMBER (of Licensee)                                                                                                                     | NAME AND ADDRESS OF FACILITY                                                      |
|                                            | <i>[Signature]</i>                                                                                                                                                                                                  |                     | M-738                                                                                                                                            | Davis Mortuary                                                                    |
|                                            | TIME OF DEATH                                                                                                                                                                                                       |                     | DATE PRONOUNCED DEAD (Month, Day, Year)                                                                                                          | WAS CASE REFERRED TO CORONER?                                                     |
|                                            | 1131 M                                                                                                                                                                                                              |                     | June 15, 2001                                                                                                                                    | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>               |
| <b>CAUSE OF DEATH</b>                      | 27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                     | MANNER OF DEATH (Check one)                                                                                                                      |                                                                                   |
|                                            | IMMEDIATE CAUSE (Final disease or condition resulting in death)                                                                                                                                                     |                     | Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input checked="" type="checkbox"/> |                                                                                   |
|                                            | a. Head injuries                                                                                                                                                                                                    |                     | Instant                                                                                                                                          |                                                                                   |
|                                            | b. Crushed chest                                                                                                                                                                                                    |                     | Instant                                                                                                                                          |                                                                                   |
| <b>CERTIFIER</b>                           | 27. PART II. Other Significant Conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                          |                     | WAS AN AUTOPSY PERFORMED?                                                                                                                        |                                                                                   |
|                                            | c. Automobile accident                                                                                                                                                                                              |                     | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                              |                                                                                   |
|                                            | d. _____                                                                                                                                                                                                            |                     | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?                                                                           |                                                                                   |
|                                            | _____                                                                                                                                                                                                               |                     | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                              |                                                                                   |
| <b>CERTIFIER</b>                           | CERTIFIER (Check only one)                                                                                                                                                                                          |                     |                                                                                                                                                  |                                                                                   |
|                                            | <input type="checkbox"/> PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.                                                        |                     |                                                                                                                                                  |                                                                                   |
|                                            | <input checked="" type="checkbox"/> CORONER — 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 as stated.             |                     |                                                                                                                                                  |                                                                                   |
|                                            | SIGNATURE AND TITLE OF CERTIFIER                                                                                                                                                                                    |                     | LICENSE NUMBER                                                                                                                                   | DATE SIGNED (Month, Day, Year)                                                    |
| <b>TO BE USED FOR EXTERNAL CAUSES ONLY</b> | Doyle Jones, Coroner                                                                                                                                                                                                |                     | 555 N. Broadway, Blackfoot, ID 83221                                                                                                             | June 20, 2001                                                                     |
|                                            | DATE OF INJURY (Mo., Day, Yr.)                                                                                                                                                                                      |                     | HOUR OF INJURY                                                                                                                                   | DESCRIBE HOW INJURY OCCURRED                                                      |
|                                            | June 15, 2001                                                                                                                                                                                                       |                     | 1101                                                                                                                                             | Decedent's car ran into back of stopped truck                                     |
|                                            | INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                 |                     | IF TRANSPORTATION ACCIDENT, Specify                                                                                                              | PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |
| <b>CORONER'S REVIEW AREA</b>               | CORONER'S ACTION (Check one)                                                                                                                                                                                        |                     | CORONER'S SIGNATURE                                                                                                                              |                                                                                   |
|                                            | (1) Reviewed Only (2) Reviewed and/or Amended, and Certified                                                                                                                                                        |                     | _____                                                                                                                                            |                                                                                   |
|                                            | DATE SIGNED (Month, Day, Year)                                                                                                                                                                                      |                     | DATE SIGNED (Month, Day, Year)                                                                                                                   |                                                                                   |
|                                            | _____                                                                                                                                                                                                               |                     | June 20, 2001                                                                                                                                    |                                                                                   |
| <b>REGISTRAR</b>                           | REGISTRAR'S SIGNATURE                                                                                                                                                                                               |                     | DATE FILED (Month, Day, Year)                                                                                                                    |                                                                                   |
|                                            | _____                                                                                                                                                                                                               |                     | June 20, 2001                                                                                                                                    |                                                                                   |

\*At a minimum, complete items 1; 3, 9a, b, c, d; 21a, b; 22; and 29e for the 24 Hour Report & Authorization For Final Disposition

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

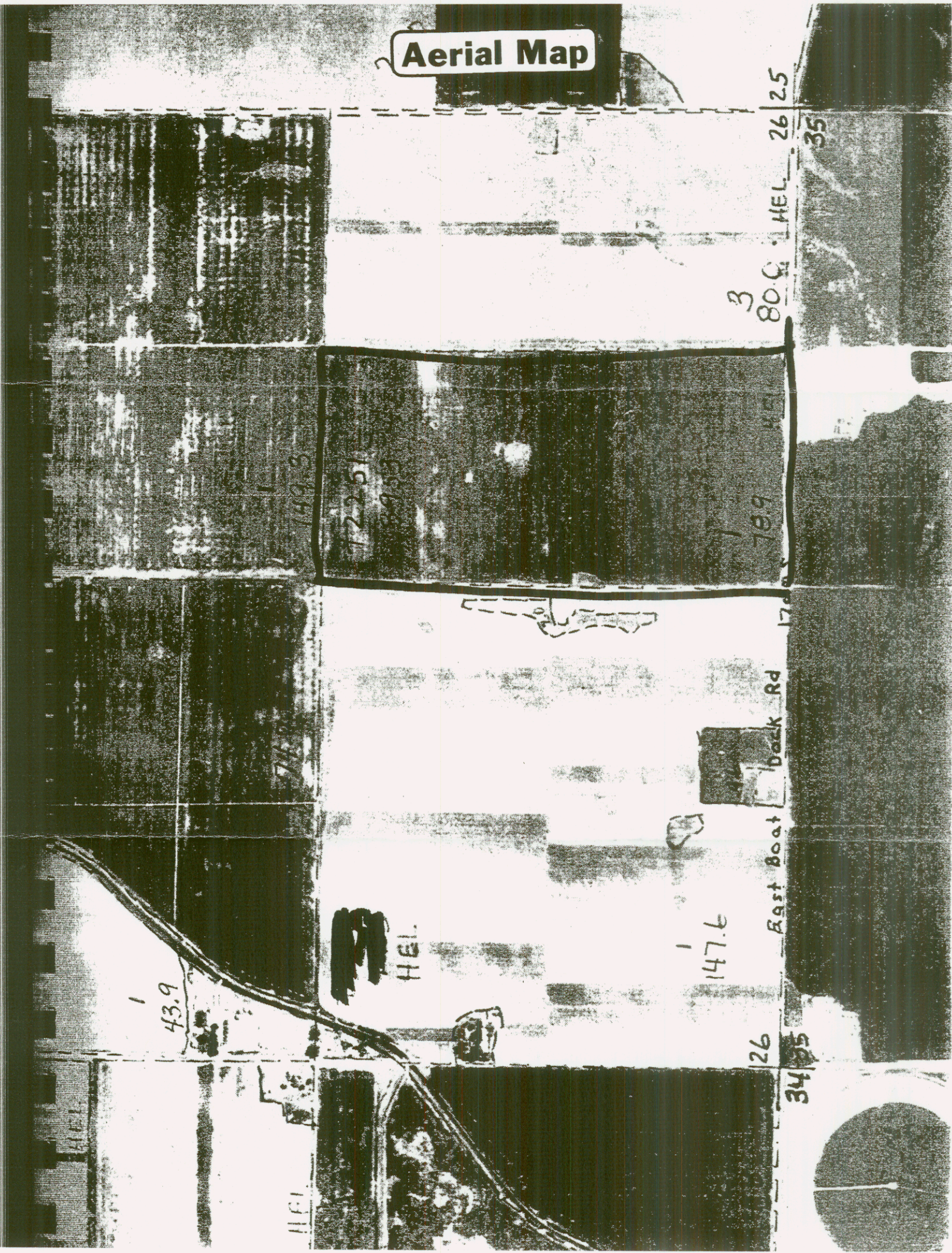
DATE ISSUED: June 20, 2001

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

JANE S. SMITH  
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

Aerial Map



# Aerial Map

Transfer to Power City

+2250  
3953

79.3

1885

1885

3 2

3

34 35

4.1

30.1 54.1