

STATE OF IDAHO CERTIFICATION OF VITAL RECORD

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

RECEIVED

JUN 16 2021

State of Idaho CERTIFICATE OF DEATH

IDAHO DEPARTMENT OF
WATER RESOURCES

DECEDENT TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT-TIP PEN FOR INSTRUCTIONS SEE HANDBOOK	1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix) JAMES EUGENE MENGELKAMP		2. SEX MALE	3. SOCIAL SECURITY NUMBER [REDACTED]
	4a. AGE Last Birthday 87 (Years)	4b. UNDER 1 YEAR Months Days Hours Minutes	4c. UNDER 1 DAY 01/25/1933	5. DATE OF BIRTH (Mo/Day/Yr) 01/25/1933
PARENTS 10. EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No	7a. RESIDENCE - STATE OR FOREIGN COUNTRY IDAHO		7b. COUNTY LATAH	
	7c. CITY OR TOWN MOSCOW		7d. STREET AND NUMBER 3215 HWY 8	
INFORMANT 13a. INFORMANT'S NAME (Type or print) TONY MENGELKAMP	13b. RELATIONSHIP TO DECEDENT SON		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 3215 HWY 8 MOSCOW, ID 83843	
	14. METHOD OF DISPOSITION ☐ Burial ☐ Donation ☒ Removal from Idaho ☐ Other (Specify)		15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place) WHEATLAND CREMATORY SOUTH 905 GRAND AVE PULLMAN, WASHINGTON 99163	
DISPOSITION 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ELECTRONICALLY FILED: DAVE L. HUTTON	17b. LICENSE NUMBER (Of licensee) M0651		18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? ☐ Yes ☒ No	
	19. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY SHORT'S FUNERAL CHAPEL 1225 EAST SIXTH STREET MOSCOW, IDAHO 83843		20. FACILITY NAME (If not facility, give street and number) 3215 HWY 8	
PLACE OF DEATH 21a. IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Outpatient ☐ OOA	21b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Home ☐ Nursing home ☐ Long-term care facility ☐ Decedent's home ☐ Other (Specify)		21c. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE MOSCOW, ID 83843	
	22. COUNTY OF DEATH LATAH		23. DATE OF DEATH (Mo/Day/Yr) (Spell month) May 3, 2020	
DATE OF DEATH 24. TIME OF DEATH (24hr) 09:30	25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) May 3, 2020		26. TIME PRONOUNCED DEAD (24hr) 09:30	
	27. CAUSE OF DEATH PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT abbreviate. Enter only one cause on a line. DIASTOLIC HEART FAILURE DUE TO (or as a consequence of): a. DIASTOLIC HEART FAILURE b. UNKNOWN c. UNKNOWN d. UNKNOWN			
CAUSE OF DEATH PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE; METABOLIC ENCEPHALOPATHY	28. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No		29. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☒ No	
	30. IF FEMALE (Aged 16-54): ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Unknown if pregnant within the past year		31. MANNER OF DEATH ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined	
REMARKS 32. DATE OF INJURY (Mo/Day/Yr) (Spell month) May 3, 2020	33. TIME OF INJURY (24hr) 09:30		34. PLACE OF INJURY (Describe home, farm, street, construction site, nursing home, restaurant, forest, etc.) 3215 HWY 8, MOSCOW, IDAHO	
	35. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____ Street and Number or Location _____		36. DESCRIBE HOW INJURY OCCURRED, IF TRANSPORTATION INJURY, STATE THE TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable	
CERTIFIER 37a. WAS DECEDENT: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)	37b. WHAT SAFETY DEVICES(S) DID DECEDENT USE/EMPLOY? ☐ Seat belt ☐ Child safety seat ☐ Helmet ☐ Air bag ☐ None ☐ Unknown		38. LICENSE NUMBER M-09634	
	39. CERTIFIER (Check only one, based on official capacity for this certificate): ☒ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ ADVANCED PRACTICE REGISTERED NURSE ☐ CORONER To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) stated. Signature and Title of Certifier: ELECTRONICALLY SIGNED: ELIZABETH L. BLACK, M.D. 39a. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print) ELIZABETH L. BLACK, 1271 HIGHLAND AVE STE B CLARKSTON, WA 99403		38c. DATE SIGNED 5 / 4 / 2020 MM DD YYYY	
REGISTRAR 40a. REGISTRAR'S SIGNATURE James B. Gallo	40b. DATE SIGNED 5 / 5 / 2020 MM DD YYYY		40c. DATE SIGNED 5 / 5 / 2020 MM DD YYYY	

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

DATE ISSUED: **MAY 06 2020**

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

JAMES B. AYDELOTTE
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE