

STATE OF IDAHO
DEPARTMENT OF WATER RESOURCES

RECEIVED

APR 14 2017

Notice of Change in Water Right Ownership

DEPT OF WATER RESOURCES
SOUTHERN REGION

1. List the numbers of all water rights and/or adjudication claim records to be changed. If you only acquired a portion of the water right or adjudication claim, check "Yes" in the "Split?" column. If the water right is leased to the Water Supply Bank, check "Yes". If you are not sure if the water right is leased to the Water Supply Bank, see #6 of the instructions.

Water Right/Claim No.	Split?	Leased to Water Supply Bank?	Water Right/Claim No.	Split?	Leased to Water Supply Bank?
45-13577	Yes ☐	Yes ☐		Yes ☐	Yes ☐
45-14419	Yes ☐	Yes ☐		Yes ☐	Yes ☐
45-14420	Yes ☐	Yes ☐		Yes ☐	Yes ☐
	Yes ☐	Yes ☐		Yes ☐	Yes ☐
	Yes ☐	Yes ☐		Yes ☐	Yes ☐

2. Previous Owner's Name: Bret Adams Cindy Adams
Name of current water right holder/claimant
3. New Owner(s)/Claimant(s): Cindy Adams
New owner(s) as listed on the conveyance document Name connector ☐ and ☐ or ☐ and/or
- PO Box 85 Albion ID 83311
Mailing address City State ZIP
- 208-673-6267 cubby@atcnet.net
Telephone Email

4. If the water rights and/or adjudication claims were split, how did the division occur?
☐ The water rights or claims were divided as specifically identified in a deed, contract, or other conveyance document.
☐ The water rights or claims were divided proportionately based on the portion of their place(s) of use acquired by the new owner.
5. Date you acquired the water rights and/or claims listed above: _____
6. If the water right is leased to the Water Supply Bank changing ownership of a water right will reassign to the new owner any Water Supply Bank leases associated with the water right. Payment of revenue generated from any rental of a leased water right requires a completed IRS Form W-9 for payment to be issued to an owner. A new owner for a water right under lease shall supply a W-9. Water rights with multiple owners must specify a designated lessor, using a completed Lessor Designation form. Beginning in the calendar year following an acknowledged change in water right ownership, compensation for any rental will go to the new owner(s).
7. This form must be signed and submitted with the following **REQUIRED** items:
☐ A copy of the conveyance document – warranty deed, quitclaim deed, court decree, contract of sale, etc. The conveyance document must include a legal description of the property or description of the water right(s) if no land is conveyed.
☐ Plat map, survey map or aerial photograph which clearly shows the place of use and point of diversion for each water right and/or claim listed above (if necessary to clarify division of water rights or complex property descriptions).
☐ Filing fee (see instructions for further explanation):
 o \$25 per *undivided* water right.
 o \$100 per *split* water right.
 o No fee is required for pending adjudication claims.
☐ If water right(s) are leased to the Water Supply Bank AND there are multiple owners, a Lessor Designation form is required.
☐ If water right(s) are leased to the Water Supply Bank, the individual owner or designated lessor must complete, sign and submit an IRS Form W-9.

SUPPORT DATA

IN FILE # 45-13577

8. Signature: Cindy Adams 3-31-17
Signature of new owner/claimant Title, if applicable Date
- Signature: _____
Signature of new owner/claimant Title, if applicable Date

For IDWR Office Use Only:

Received by _____ Date _____ Receipt No. _____ Receipt Amt. _____

Active in the Water Supply Bank? Yes ☐ No ☐ If yes, forward to the State Office for processing

Name on W-9 _____ Approved by _____ Processed by B. J. M. W-9 received? Yes ☐ No ☐

Date 4/25/17

STATE OF IDAHO

CERTIFICATION OF VITAL RECORD

STATE OF IDAHO

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

DATE FILED BY STATE REGISTRAR:

State of Idaho

CERTIFICATE OF DEATH

STATE FILE NO. 2012-11848

01/02/2013

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THE SIGNATURE OF HEALTH AND WELFARE SECRETARY, SHALL BE SENT TO THE COUNTY CLERK OF THE COUNTY WHERE THE DECEASED RESIDED AND TO THE LOCAL HEALTH DEPARTMENT.

Local Reg. No.

DECEASED TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN FOR INSTRUCTIONS SEE HANDBOOK DATE OF DEATH CAUSE OF DEATH 7-8-19	1. DECEASED'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix) BRET DARRELL ADAMS	2. SEX MALE	3. SOCIAL SECURITY NUMBER [REDACTED]		
	4a. AGE-Last Birthday 50	4b. UNDER 1 YEAR 4c. UNDER 1 DAY	5. DATE OF BIRTH (Mo/Day/Yr) 04/18/1962		
	6. BIRTHPLACE (City and State, Territory, or Foreign Country) BURLEY, IDAHO				
	7a. RESIDENCE - STATE OR FOREIGN COUNTRY IDAHO		7b. COUNTY CASSIA		
	7c. CITY OR TOWN ALBION				
7d. STREET AND NUMBER 1030 EAST 900 SOUTH		7e. APT. NO.	7f. ZIP CODE 83311	7g. INSIDE CITY LIMITS? ☐ Yes ☒ No	
8. MARITAL STATUS AT TIME OF DEATH ☒ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never married ☐ Unknown				9. SURVIVING SPOUSE'S NAME (If wife, give maiden name) CINDY LOU TAYLOR	
10. EVER IN U.S. FORCES? ☐ Yes ☒ No		11a. FATHER'S NAME (First, Middle, Last, Suffix) ROBERT HOWARD ADAMS		11b. BIRTHPLACE (State, Territory, or Foreign Country) UTAH	
12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) JENEAL QUARNSTROM		12b. BIRTHPLACE (State, Territory, or Foreign Country) IDAHO		13a. INFORMANT'S NAME (Type or print) CINDY LOU ADAMS	
13b. RELATIONSHIP TO DECEDENT WIFE		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) P.O. BOX 85 ALBION, ID 83311			
14. METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from Idaho ☐ Other (Specify)		15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place) MORMON CEMETERY ALBION, IDAHO 83311		16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY RASMUSSEN FUNERAL HOME 1350 EAST 16TH STREET BURLEY, IDAHO 83318	
17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ELECTRONICALLY FILED: JEFFREY H. RASMUSSEN		17b. LICENSE NUMBER (If licensee) M0717		18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? ☒ Yes ☐ No	
19a. IF DEATH OCCURRED IN A HOSPITAL: 19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Incident ☐ Outpatient ☐ OCA ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☒ Other (Specify) MOUNT HARRISON					
20. FACILITY NAME (If facility, give street and number) N 42.32892 W 113.80907		21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE ALBION, ID 83311		22. COUNTY OF DEATH CASSIA	
23. DATE OF DEATH (Mo/Day/Yr) (Spell month) December 30, 2012		24. TIME OF DEATH (24hr) Estimated 18:18 - 18:30		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) December 30, 2012	
26. TIME PRONOUNCED DEAD (24hr) 17:19		27. CAUSE OF DEATH PART 1. 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) a. ACUTE MYOCARDIAL INFARCTION DUE TO (or as a consequence of): b. _____ c. _____ d. _____			
PART 2. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part 1. NONE					
28. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown		29. IF FEMALE (Aged 15-44): ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Not pregnant, but pregnant within 42 days of death ☐ Unknown if pregnant within the past year		30a. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No	
30b. MANNER OF DEATH ☒ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined		31. INJURY AT WORK? ☐ Yes ☒ No			
32. DATE OF INJURY (Mo/Day/Yr) (Spell month)		33. TIME OF INJURY (24hr)		34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)	
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					
38a. WAS DECEDENT: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)		38b. WHAT SAFETY DEVICES 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) ☐ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ ADVANCED PRACTICE PROFESSIONAL NURSE To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) stated.	
39b. 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 stated.		39c. LICENSE NUMBER		39d. DATE SIGNED 12 / 31 / 2012 MM DO YYYY	
Signature and Title of Certifier ELECTRONICALLY SIGNED: CRAIG RINEHART					
39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print) CRAIG RINEHART, 135 DENNIS CIRCLE BURLEY, ID 83318					
40a. REGISTRAR'S SIGNATURE James B. Galt		40b. DATE SIGNED 1 / 2 / 2013 MM DO 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.

JAN 02 2013

DATE ISSUED:

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

JAMES B. AYDELOTTE
STATE REGISTRAR

PRNCD (Rev) 02/12