

STATE OF IDAHO
DEPARTMENT OF WATER RESOURCES

RECEIVED

DEC 16 2013

Notice of Change in Water Right Ownership

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.

Water Right/Claim No.	Split?	Water Right/Claim No.	Split?	Water Right/Claim No.	Split?
29-2041	Yes ☐	29-10588	Yes ☐		Yes ☐
29-2395	Yes ☐	29-10589	Yes ☐		Yes ☐
29-4495	Yes ☐	29-10590	Yes ☐		Yes ☐
29-10586	Yes ☐	29-10591	Yes ☐		Yes ☐
29-10587	Yes ☐		Yes ☐		Yes ☐

2. Previous Owner's Name:

Harry R. Hartwigson, David J. Hart, Robert E. Hart
Name of current water right holder/claimant

3. New Owner(s)/Claimant(s):

James W. Hart, David J. Hart, Robert E. Hart
Name of each new owner as listed on the conveyance document

New owner continued

Name connector ☐ and ☐ or ☐ and/or

P.O. Box 5321

Mailing address

Chubbuck,

City

208-251-7092

Telephone

ID

State

83202

ZIP

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. 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):
 - \$25 per undivided water right.
 - \$100 per split water right.
 - No fee is required for pending adjudication claims.

7. Signature:

Robert E. Hart

Signature of new owner/claimant

Title, if applicable

Dec 16, 2013

Date

- Signature:

James Hart

Signature of new owner/claimant

Title, if applicable

Date

For IDWR Office Use Only:

Fee not required

Received by

Date

Receipt No.

Receipt Amt.

Approved by

Processed by

Date

CERTIFICATE OF VITAL RECORD

STATE OF IDAHO

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

State of Idaho CERTIFICATE OF DEATH

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR, WITH THIS DEPT. OF HEALTH & WELFARE RAISED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH UNDER IDAHO CODE 35-2411A & 35-271

State File No _____
Local Reg. No. 6-605

DECEDENT	DECEDENT - NAME FIRST MIDDLE LAST		SEX	DATE OF DEATH (Month, Day, Year)
	1. <u>Harry Richard Hartwigsen</u>		2. <u>Male</u>	3. <u>December 14, 2001</u>
TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN	SOCIAL SECURITY NUMBER		AGE - Last birthday (Yrs)	DATE OF BIRTH (Month, Day, Year)
	4. _____		5. <u>71</u>	6. <u>Apr 14, 1930</u>
NAME OF DECEDENT For use by physician or institution	WAS DECEDENT EVER IN U.S. ARMED FORCES?		PLACE OF DEATH (Check only one)	OTHER
	7. ☒ Yes ☐ No		8. (1) ☒ Inpatient (2) ☐ ER/Outpatient (3) ☐ DOA (4) ☐ Long-Term Care Facility (5) ☐ Own Residence (6) ☐ Other Private Residence (7) ☐ Other (Specify) _____	
NAME OF DECEDENT For use by physician or institution	FACILITY NAME AND ADDRESS (If not a hospital, enter name of place, street and number)		CITY, TOWN OR LOCATION OF DEATH	COUNTY OF DEATH
	9. <u>Pocatello Regional Medical Center</u>		10. <u>Pocatello</u>	11. <u>Bannock</u>
NAME OF DECEDENT For use by physician or institution	MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify)	SURVIVING SPOUSE (If wife, give maiden name)	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	KIND OF BUSINESS / INDUSTRY
	12. <u>Divorced</u>	13. _____	14. <u>Floor Manager</u>	15. <u>Casino</u>
NAME OF DECEDENT For use by physician or institution	RESIDENCE STATE	COUNTY	CITY, TOWN OR LOCATION	STREET AND NUMBER
	16. <u>ID</u>	17. <u>Bannock</u>	18. <u>Chubbuck</u>	19. <u>9250 E. Chubbuck Rd.</u>
NAME OF DECEDENT For use by physician or institution	INSIDE CITY LIMITS?	WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	RACE - American Indian, Black, Japanese, White, etc. (Specify)	18. DECEDENT'S EDUCATION (Specify only highest grade completed)
	20. ☐ Yes ☒ No	21. ☐ Yes ☒ No	22. <u>White</u>	23. <u>Elementary/Secondary (8-12)</u> <u>College (1-4 or 5+)</u>
PARENTS	FATHER - NAME		BIRTHPLACE	MOTHER - FULL MAIDEN NAME
	17a. <u>Harry Christian Hart</u>		17b. <u>New Jersey</u>	17c. <u>Florence L. Richardson</u>
INFORMANT	INFORMANT'S NAME (Type/Print)		MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	18a. <u>Jim Hart</u>		18b. <u>Box 5231, Chubbuck, ID 83202</u>	
DISPOSITION	METHOD OF DISPOSITION		PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	LOCATION - City or Town, State
	24. ☒ Burial ☐ Cremation ☐ Removal from Idaho ☐ Donation ☐ Other (Specify) _____		25. <u>Inkom Cemetery</u>	26. <u>Inkom, ID</u>
CAUSE OF DEATH	SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH		LICENSE NUMBER (of Licensee)	NAME AND ADDRESS OF FACILITY
	27a. <u>Graig W. Bann</u>		27b. <u>M-789</u>	27c. <u>Colonial Funeral Home</u> <u>2005 South Fourth Avenue Pocatello, ID</u>
CAUSE OF DEATH	TIME OF DEATH	DATE PRONOUNCED DEAD (Month, Day, Year)	WAS CASE REFERRED TO CORONER?	MANNER OF DEATH (Check one)
	28. <u>7:45 PM</u>	29. <u>December 14, 2001</u>	30. ☐ Yes ☒ No	31. ☒ Natural ☐ Homicide ☐ Suicide ☐ Accident ☐ Pending Investigation ☐ Could not be Determined
CAUSE OF DEATH	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.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) IMMEDIATE CAUSE a. <u>Renal failure</u> b. <u>Diabetic nephropathy</u> c. <u>Diabetes mellitus</u> d. _____		10 years 10 years 15 years	
CAUSE OF DEATH	27. PART II. Other Significant Conditions contributing to death but not resulting in the underlying cause given in Part I		WAS AN AUTOPSY PERFORMED?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	32. <u>Multiple cerebral infarction</u>		33. ☐ Yes ☒ No	34. ☐ Yes ☒ No
CERTIFIER	CERTIFIER (Check only one)		SIGNATURE AND TITLE OF CERTIFIER	
	35. ☒ 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. 36. ☐ 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.		37. <u>L. Anderson M.D.</u>	
CERTIFIER	NAME AND ADDRESS OF CERTIFIER (Type/Print)		LICENSE NUMBER	DATE SIGNED (Month, Day, Year)
	38. <u>Dr. Lynn Anderson 500 So 11th Ave., Pocatello, ID 83201</u>		39. <u>2M 2268</u>	40. <u>12-19-01</u>
TO BE USED FOR EXTERNAL CAUSES ONLY	DATE OF INJURY (Mo., Day, Yr.)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED	
	41. _____	42. _____	43. _____	
CORONER'S REVIEW AREA	INJURY AT WORK?	IF TRANSPORTATION ACCIDENT, Specify	PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)	LOCATION (Street or Route Number, City/Town or County, and State)
	44. ☐ Yes ☒ No	45. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____	46. _____	47. _____
REGISTRAR	CORONER'S ACTION (Check one)		CORONER'S SIGNATURE	DATE SIGNED (Month, Day, Year)
	48. (1) ☐ Reviewed Only (2) ☐ Reviewed and/or Amended and Certified		49. _____	50. _____
REGISTRAR	REGISTRAR'S SIGNATURE		DATE FILED (Month, Day, Year)	
	51. <u>[Signature]</u>		52. <u>Dec. 19, 2001</u>	

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: Dec. 19, 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



The Commonwealth of Massachusetts

STANDARD CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

REGISTERED NUMBER

STATE USE ONLY

DECEDENT - NAME			SEX		DATE OF DEATH (Mo., Day, Yr.)	
1 LAUREL LOUISE TAYLOR			2 F		3 SEPTEMBER 9, 2006	
1 PLACE OF DEATH (City/Town)			COUNTRY OF DEATH		HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)	
4a FAIRHAVEN			4b BRISTOL		4c 6 BRAE ROAD	
5 PLACE OF DEATH (Check only one): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA OTHER: ☐ Nursing Home ☒ Residence ☐ Other (Specify)			6 SOCIAL SECURITY NUMBER		7 IF US WAR VETERAN SPECIFY WAR	
8a WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.) ☒ NO ☐ YES			8b RACE (e.g. White, Black, American Indian, etc.) (Specify) WHITE		9 DECEDENT'S EDUCATION (Highest Grade Completed) Elementary Sec (0-12) College (1-4, 5+)	
10a AGE - Last Birthday (Yrs.) 75			10b UNDER 1 YEAR MOS DAYS		10c UNDER 1 DAY HOURS MINS	
11 DATE OF BIRTH (Mo., Day, Yr.) MAY 25, 1931			12 BIRTHPLACE (City and State or Foreign Country) POCATELLO, IDAHO			
13a MARRIED, NEVER MARRIED WIDOWED OR DIVORCED DIVORCED			13b LAST SPOUSE (If wife, give maiden name) RICHARD TAYLOR		14a USUAL OCCUPATION (Prior - If Retired) CLAIMS REPRESENTATIVE	
15a RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY 6 BRAE ROAD, FAIRHAVEN, BRISTOL, MASSACHUSETTS			15b ZIP CODE 02719		16 KIND OF BUSINESS OR INDUSTRY FEDERAL GOVERNMENT	
17 FATHER - FULL NAME HARRY HART			18 STATE OF BIRTH (If not in US, name country) NEW JERSEY		19 MOTHER - NAME (GIVEN) (MAIDEN) FLORENCE RICHARDSON	
20 INFORMANT'S NAME STEVEN R. TAYLOR			21 MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE 42 SPRING ST., BRISTOL, RI 02809		22 RELATIONSHIP SON	
23 METHOD OF IMMEDIATE DISPOSITION ☐ BURIAL ☒ CREMATION ☐ ENTOMBMENT ☐ REMOVAL FROM STATE ☐ DONATION ☐ OTH. SPEC.			24 FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE BETTE TRZNADEL		25 LICENSE # 7377	
26a PLACE OF DISPOSITION (Name of Cemetery, Crematory or other) RIVER-SIDE CREMATORY			26b LOCATION (City/Town, State) FAIRHAVEN, MASSACHUSETTS			
27 DATE OF DISPOSITION (Mo., Day, Yr.) SEPTEMBER 13, 2006			28a/b NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE FAIRLAWN MORTUARY 180 WASHINGTON ST., FAIRHAVEN, MA 02719			
29 PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. METASTATIC ADENOCARCINOMA UNKNOWN PRIMARY Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST b. c. d. Approximate Interval Between Onset and Death c. 4-6 WKS						
PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I. 30 MED. EXAM NOTIFIED? (Yes or No) NO 31 WAS AUTOPSY PERFORMED? (Yes or No) NO 32 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) 33 DESCRIBE HOW INJURY OCCURRED 34 MANNER OF DEATH ☒ NATURAL ☐ HOMICIDE ☐ COULD NOT BE DETERMINED ☐ ACCIDENT ☐ SUICIDE ☐ PENDING INVESTIGATION 35a DATE OF INJURY (Mo., Day, Yr.) 35b TIME OF INJURY 35c INJURY AT WORK (Yes or No) 35d PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.) Specify 35e LOCATION (No. & St., City/Town, State) 36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title) 36b DATE SIGNED (Mo., Day, Yr.) 36c HOUR OF DEATH 36d NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER 37a 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) stated. (Signature and Title) 37b DATE SIGNED (Mo., Day, Yr.) 37c HOUR OF DEATH 37d PRONOUNCED DEAD (Mo., Day, Yr.) 37e PRONOUNCED DEAD (Hr) 37f LICENSE NO. OF CERTIFIER 38 ROBERT SAWYER, M.D. 535 FAUNCE CORNER RD., DARTMOUTH, MA 02747 39 50185 40a WAS THERE A PRONOUNCEMENT FORM? (Yes or No) YES 40b IF YES, DATE PRONOUNCED 40c IF YES, TIME PRONOUNCED 40d NAME OF PRONOUNCER 41 DATE BURIAL PERMIT ISSUED 42 SIGNATURE-BD OF HEALTH AGENT 43 RECEIVED IN THE CITY/TOWN OF CLERK'S SIGNATURE DATE OF RECORD						

A TRUE COPY, ATTEST:

Eileen M. Lowney
Eileen M. Lowney - Town Clerk