

State of Idaho CERTIFICATE OF DEATH

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR, WITH THE DEPT. 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. _____

DECEDENT

TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN

NAME OF DECEDENT
For use by physician or institution

DECEDENT — NAME FIRST MIDDLE LAST Merlin Kay Davenport			SEX Male	DATE OF DEATH (Month, Day, Year) March 11, 1999
SOCIAL SECURITY NUMBER [REDACTED]		AGE - Last Birthday (Yrs.) 67	UNDER 1 YEAR MONTHS DAYS [REDACTED]	UNDER 1 DAY HOURS MIN. [REDACTED]
DATE OF BIRTH (Month, Day, Year) [REDACTED]		BIRTHPLACE (City and State or Foreign Country) Heman, Idaho		
WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ Yes ☐ No		PLACE OF DEATH (Check only one) * HOSPITAL (1) ☐ Inpatient (2) ☐ ER/Outpatient (3) ☐ DOA OTHER (4) ☐ Long-Term Care Facility (5) ☒ Own Residence (6) ☐ Other Private Residence (7) ☐ Other (Specify) _____		
FACILITY NAME AND ADDRESS (If not a hospital, enter name of place, street and number) 6135 East Sunnyside Road			CITY, TOWN OR LOCATION OF DEATH Idaho Falls	COUNTY OF DEATH Bonneville
MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) Married		SURVIVING SPOUSE (If wife, give maiden name) Helen Elaine McCulloch		DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Owner/Operator
RESIDENCE STATE Idaho		COUNTY Bonneville	CITY, TOWN OR LOCATION Idaho Falls	STREET AND NUMBER 6135 East Sunnyside Road
INSIDE CITY LIMITS? ☐ Yes ☒ No		WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes — If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No		RACE — American Indian, Black, Japanese, White, etc. (Specify) White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		College (1-4 or 5+)		
FATHER — NAME Ira S. Davenport		BIRTHPLACE Idaho		MOTHER — FULL MAIDEN NAME Harriet Housley
BIRTHPLACE Idaho		BIRTHPLACE Utah		

PARENTS

INFORMANT

INFORMANT'S NAME (Type/Print) Helen Davenport		MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6135 East Sunnyside Road, Idaho Falls, ID 83406	
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DISPOSITION

METHOD OF DISPOSITION ☒ Burial ☐ Cremation ☐ Removal from Idaho ☐ Donation ☐ Other (Specify) _____		PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Ammon Cemetery	LOCATION — City or Town, State Ammon, Idaho
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CAUSE OF DEATH

SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <i>Chris Peterson</i>		LICENSE NUMBER (of Licensee) M-778	NAME AND ADDRESS OF FACILITY Wood Funeral Home, 273 North Ridge, Idaho Falls, ID 83402	
TIME OF DEATH 6:30 a.m.	DATE PRONOUNCED DEAD (Month, Day, Year) March 11, 1999	WAS CASE REFERRED TO CORONER? ☐ Yes ☒ No	MANNER OF DEATH (Check One) ☒ Natural ☐ Homicide ☐ Suicide ☐ Accident ☐ Pending Investigation ☐ Could Not Be Determined	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Possible Myocardial Infarction			Approximate Interval Between Onset and Death minutes	
27. PART II. Other Significant Conditions contributing to death but not resulting in the underlying cause given in Part I. _____			WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No	
			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ Yes ☐ No	

CERTIFIER

IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE

CERTIFIER (Check only one) ☒ 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. ☐ 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 <i>Dr. Boyd L. Hammond</i>		LICENSE NUMBER M3742	DATE SIGNED (Month, Day, Year) 3/15/99
NAME AND ADDRESS OF CERTIFIER (Type/Print) Dr. Boyd L. Hammond, 2065 East 17th Street, Idaho Falls, ID 83404			

TO BE USED FOR EXTERNAL CAUSES ONLY

DATE OF INJURY (Mo., Day, Yr.) [REDACTED]	HOUR OF INJURY [REDACTED]	DESCRIBE HOW INJURY OCCURRED [REDACTED]
INJURY AT WORK? ☐ Yes ☐ No		IF TRANSPORTATION ACCIDENT, Specify ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____
PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) [REDACTED]		LOCATION (Street or Route Number, City/Town, or County, and State) [REDACTED]

CORONER'S REVIEW AREA

CORONER'S ACTION (Check One) (1) ☐ Reviewed Only (2) ☐ Reviewed and/or Amended, and Certified	CORONER'S SIGNATURE [REDACTED]	DATE SIGNED (Month, Day, Year) [REDACTED]
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REGISTRAR

REGISTRAR'S SIGNATURE [REDACTED]	DATE FILED (Month, Day, Year) [REDACTED]
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