

STATE OF IDAHO

IDAHO DEPARTMENT OF HEALTH AND WELFARE

BUREAU OF HEALTH POLICY AND VITAL STATISTICS

RECEIVED
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CERTIFICATE OF DEATH

STATE FILE NO. _____

Local Reg. No. 1-437

DECEDENT TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN FOR INSTRUCTIONS SEE HANDBOOKS PARENTS INFORMANT DISPOSITION PLACE OF DEATH DATE OF DEATH CAUSE OF DEATH	* 1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix) TERRYL EUGENE MORT		2. SEX Male	3. SOCIAL SECURITY NUMBER [REDACTED]
	4a. AGE - Last Birthday 4b. UNDER 1 YEAR 4c. UNDER 1 DAY 5. DATE OF BIRTH (Mo/Da/Yr) 61 (Years) Aug 22, 1943		6. BIRTHPLACE (City and State, Territory, or Foreign Country) Eugene, OR	
7a. RESIDENCE - STATE OR FOREIGN COUNTRY 7b. COUNTY Idaho Kootenai		7c. CITY OR TOWN Post Falls		
7d. STREET AND NUMBER 2854 Kildeer		7e. APT. NO. 7f. ZIP CODE 83854		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) Diane Henke				
10. EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No		11a. FATHER'S NAME (First, Middle, Last, Suffix) Keith Mort		
12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) Bonnie Eppers		11b. BIRTHPLACE (State, Territory, or Foreign Country) Montana		
13a. INFORMANT'S NAME (Type or print) Clifford Mort		11c. BIRTHPLACE (State, Territory, or Foreign Country) Oregon		
13b. RELATIONSHIP TO DECEDENT Son		12b. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY 3201 N Huettner Road Coeur d'Alene, ID 83814 English Funeral Chapel 1700 N Spokane St. Post Falls, ID 83854		
* 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) Family Farm 2854 Kildeer Post Falls, ID 83854		
* 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH [Signature]		* 17b. LICENSE NUMBER (Of licensee) M-779		
18. PLACE OF DEATH (18-22) ☐ 18a. DEATH OCCURRED IN A HOSPITAL ☐ 18b. DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL ☐ Inpatient ☐ ER/outpatient ☐ DOA ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify)				
* 20. FACILITY NAME (If not facility, give street and number) Residence-2854 Kildeer		* 21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE Post Falls, 83854		
* 22. COUNTY OF DEATH Kootenai		* 23. DATE OF DEATH (Mo/Da/Yr) (Spell month) May 18, 2005		
* 24. TIME OF DEATH 1700 (24hr)		* 25. DATE PRONOUNCED DEAD (Mo/Da/Yr) (Spell month) May 18, 2005		
* 26. TIME PRONOUNCED DEAD 1700 (24hr)		27. CAUSE OF DEATH PART I. Enter the <u>immediate cause</u> - 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. <u>Metastatic Melanoma</u>		APPROXIMATE INTERVAL: Onset to Death 18 months		
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (Last disease or injury that initiated the events resulting in death) b. DUE TO (or as a consequence of): c. DUE TO (or as a consequence of): d. DUE TO (or as a consequence of):		PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I		
28. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown		29. IF FEMALE (Aged 15-64): ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Not pregnant, but pregnant within 42 days of death		
30. DATE OF INJURY (Mo/Da/Yr) (Spell month) [Blank]		31. MANNER OF DEATH ☒ Natural ☐ Homicide ☐ Accident ☐ Pending investigation ☐ Suicide ☐ Could not be determined		
32. TIME OF INJURY [Blank] (24hr)		33. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.) [Blank]		
34. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____ Street and Number or Location _____ Apartment Number _____				
35. 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 [Blank]				
36. TRANSPORTATION 36a. WAS DECEDENT: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) 36b. WHAT SAFETY DEVICE(S) DID DECEDENT USE/EMPLOY? ☐ Seat belt ☐ Child safety seat ☐ Helmet ☐ Air bag ☐ None ☐ Unknown				
37a. CERTIFIER (Check only one, based on official capacity for this certificate) ☒ PHYSICIAN - To the best of my knowledge, death occurred at the time, date, and place, and due to the <u>cause(s)</u> 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 <u>cause(s)</u> and manner stated.		38. DATE SIGNED m 6841 05/23/2005 MM DD YYYY		
39. SIGNATURE AND TITLE OF CERTIFIER Haluk Tezcan, MD 700 Ironwood Dr., Coeur d'Alene, ID 83814		40. CORONER'S SUBSEQUENT SIGNATURE IF NECESSARY: The coroner's signature in this item supersedes that of the physician, and the coroner becomes the certifier of record. [Signature]		
41. REGISTRAR'S SIGNATURE [Signature]		42. DATE SIGNED 05/26/2005 MM DD YYYY		

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

DATE ISSUED:

MAY 26 2005

This copy 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

001661202

STATE OF IDAHO County of Kootenai

This copy of a death certificate was issued by the District Health Department prior to filing with the Bureau of Vital Records and Health Statistics.

Local Vital Statistics Registration Official

[Signature]