

RECEIVED

STATE OF IDAHO
DEPARTMENT OF WATER RESOURCES
STATEMENT OF COMPLETION
FOR SUBMITTING PROOF OF BENEFICIAL USE

FOR OFFICE USE ONLY

Amt. of Fee \$ _____

Receipt No. _____

Received By _____

Date Received _____

The Idaho Department of Water Resources (Department) considers this form a statement that the permit holder(s) applied water to beneficial use and completed development of a water right to the extent described below. **This form must be accompanied by an examination fee, when necessary, or by a completed Beneficial Use Field Report prepared by a certified water right examiner (CWRE).** Please refer to the instructions and fee schedule for this form. If ownership of the permit has changed, complete a Notice of Change in Water Right Ownership form. If you wish to relinquish your permit because you have not established the authorized water use and are not applying for an extension, please notify the Department in writing.

1. Permit No. 404-105 Name of Permit Holder(s) CATHERINE S. BROOKS

Telephone No. 208-457-0628 Email n/a

Mailing Address 475 S. Prestige Ct City Post Falls State ID Zip 83854

2. Source of Water Ground Water If Ground Water (well), Date Drilled mo. 6 /yr. 2005

Drilling Permit/Tag No. D0040245 Drilling Company's Name Agua Drilling and Exploration Inc.

3. Extent of use(s) completed as authorized by the water right permit:

Domestic (No. households) 1 Irrigation (No. acres) — Stockwater (No. and stock type) —

Other _____

4. Total diversion rate or volume (storage only) for which proof is submitted 0.04 cfs OR _____ af
If the total developed water use is 5 acres of irrigation or less, is stockwater storage of 14.6 acre-feet or less, or has a diversion rate of less than 0.24 cfs, attach a map of the place of use and point of diversion and photographs showing beneficial use.

5. Describe the diversion and delivery system from the water source to the use (pump, lift, irrigation method, etc.)

EXISTING WELL, PUMP, AND PIPES TO PRESSURE TANK

6. Permit condition compliance. Refer to the permit approval conditions and check all the items required, then check "Yes" or "No" to indicate whether the required items were established, submitted, and/or installed:

Required? Yes No (If "Yes", attach required data, evidence of compliance, or evidence of installation)

- | | | |
|--------------------------|-------------------------------------|---|
| ☐ | ☒ | Ground water level data, pumping information, or other diversion data |
| ☐ | ☒ | Mitigation plan |
| ☐ | ☒ | Lockable controlling works |
| ☐ | ☒ | Measuring device |
| ☐ | ☒ | Fish screen |
| ☐ | ☒ | Other requirements of the water right permit _____ |
| ☐ | ☒ | Reasonably Anticipated Future Needs ("RAFN") Municipal use |

If RAFN Municipal use, additional increment of beneficial use developed? ☐ Yes (attach CWRE report) ☒ No

7. Fee Enclosed \$ 100 or ☐ CWRE field report attached or ☐ No fee required

See fee schedule on page 3 of the instructions. Proof statements filed without an appropriate fee are incomplete.

8. Person to contact to accompany a Department representative during the field examination of the water system:

Name: CATHERINE S. BROOKS Telephone No. 208.457.0628 Email N/A
Mailing Address 475 S. Prestige Ct City POST FALLS State ID Zip 83854

The information given on this form is my true statement of the extent to which the above numbered permit has been developed and water has been diverted and applied to beneficial use. I understand that any undeveloped portion of the permit is relinquished to the State of Idaho.

Catherine S. Brooks CATHERINE S. BROOKS, OWNER 9 September 2025
SIGNATURE OF PERMIT HOLDER* PRINTED NAME AND TITLE DATE

*Attach power of attorney if completing on behalf of permit holder.

STATE OF IDAHO CERTIFICATION OF VITAL RECORD

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

COPY

State of Idaho CERTIFICATE OF DEATH

THIS IS A COPY OF THE ORIGINAL CERTIFICATE OF DEATH. IT IS NOT VALID UNLESS IT IS PREPARED ON AN ENGRAVED BORDER AND PLACED ON FILE WITH THE IDAHO BUREAU OF VITAL RECORDS AND HEALTH STATISTICS.

Local Reg. No.

DECEDENT TYPE OR PRINT IN PERMANENT BLACK INK. DO NOT USE FELT-TIP PEN. FOR INSTRUCTIONS SEE HANDBOOKS.	1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix) FOREST CLYDE BROOKS		2. SEX MALE		3. SOCIAL SECURITY NUMBER [REDACTED]	
	4a. AGE - Last Birthday 75 (Years)		4b. UNDER 1 YEAR Months: [REDACTED] Days: [REDACTED] Hours: [REDACTED] Minutes: [REDACTED]		5. DATE OF BIRTH (Mo/Day/Yr) [REDACTED]	
	6. BIRTHPLACE (City and State, Territory, or Foreign Country) SEATTLE, WASHINGTON					
	7a. RESIDENCE - STATE OR FOREIGN COUNTRY IDAHO		7b. COUNTY KOOTENAI		7c. CITY OR TOWN POST FALLS	
	7d. STREET AND NUMBER 476 S. PRESTIGE CT.		7e. APT. NO. [REDACTED]		7f. ZIP CODE 83854	
PARENTS Complete/Verify and File Within 5 Days of Death.	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) CATHERINE SUSAN BURNS			
	10. EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No					
	11a. FATHER'S NAME (First, Middle, Last, Suffix) CLYDE BROOKS		11b. BIRTHPLACE (State, Territory, or Foreign Country) WASHINGTON			
	11c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) ANGELA KENNEDY		11d. BIRTHPLACE (State, Territory, or Foreign Country) WASHINGTON			
	12a. INFORMANT'S NAME (Type of person) CATHERINE BROOKS		12b. RELATIONSHIP TO DECEDENT SPOUSE		12c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 476 S. PRESTIGE CT. POST FALLS, ID 83854	
DISPOSITION Complete/Verify and File Within 72 Hours of Death.	13. METHOD OF DISPOSITION ☒ Burial ☐ Donation ☐ Removal from Idaho ☐ Other (Specify):		14. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place) QUEEN OF PEACE CEMETERY 5910 S. BEN BURR RD. SPOKANE, WASHINGTON 99223		15. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY BELL TOWER FUNERAL HOME AND CREMATORY 3398 EAST JENALAN STREET POST FALLS, IDAHO 83854	
	16a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ELECTRONICALLY FILED: STEPHANE GARCIA		16b. LICENSE NUMBER (Of licensee) M1588		16c. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? ☐ Yes ☒ No	
	17. PLACE OF DEATH (If-22) ☒ In hospital ☐ In residence ☐ In nursing home ☐ In hospice facility ☐ In long-term care facility ☐ In decedent's home ☐ Other (Specify):					
	18a. IF DEATH OCCURRED IN A HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ Outpatient		18b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ In residence ☐ In nursing home ☐ In hospice facility ☐ In long-term care facility ☐ In decedent's home ☐ Other (Specify):			
	19. FACILITY NAME (If not facility, give street and number) KOOTENAI HEALTH		20. CITY, TOWN OR LOCATION OF DEATH, AND ZIP CODE COEUR D'ALENE, ID 83814		21. COUNTY OF DEATH KOOTENAI	
DATE OF DEATH Complete/Verify and File Within 72 Hours of Death.	22. DATE OF DEATH (Mo/Day/Yr) (Spell month) March 21, 2023		23. TIME OF DEATH (24hr) 22:10		24. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) March 21, 2023	
	25. TIME PRONOUNCED DEAD (24hr) 22:10					
	26. CAUSE OF DEATH PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT omit 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. ACUTE INFERIOR ST-ELEVATION MYOCARDIAL INFARCTION DUE TO (or as a consequence of): CARDIOGENIC SHOCK DUE TO (or as a consequence of): ACUTE HYPOXEMIC RESPIRATORY FAILURE DUE TO (or as a consequence of): CORONARY ARTERY DISEASE					
	27. MULTIPLE ORGAN FAILURE					
	28. IF FEMALE (Ages 15-64): ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Unknown if pregnant within the past year					
CAUSE OF DEATH Complete/Verify and File Within 72 Hours of Death.	29. DATE OF INJURY (Mo/Day/Yr) (Spell month) [REDACTED]		30. TIME OF INJURY (24hr) [REDACTED]		31. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.) [REDACTED]	
	32. LOCATION OF INJURY: State: [REDACTED] City/Town or County: [REDACTED] Zip Code: [REDACTED]		33. 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. TRANSPORTATION - 33a. WAS DECEDENT: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify): ☐ What safety device(s) did decedent use/employ? ☐ Seat belt ☐ Child safety seat ☐ Helmet ☐ Air bag ☐ None ☐ Unknown			
	34. 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: ERICK MONTERO, M.D. 35a. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type of print) ERICK MONTERO, 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		36. CERTIFICATE NUMBER M-14457			
	37. DATE SIGNED 3 / 28 / 2023		38. DATE SIGNED 3 / 28 / 2023			
	39. REGISTRAR SIGNATURE James B. Aydelotte		40. DATE SIGNED 3 / 28 / 2023			

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: **MAR 30 2023**

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

Rev 07/26/20

JAMES B. AYDELOTTE
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

RECEIVED

JAN 20 2026

DEPT. OF WATER RESOURCES

7/14/26

Idaho Department of Water Resources

attn: Debra Mansfield

Re: Permit No. 9518015

This is to request that my late husband, Forest C. Brooks, name be removed from the water permit we had together. Thank you for your assistance. Thank you for all that you do.

Sincerely,

Catherine L. Brooks
475 S. Prestige Ct.
Post Falls, ID 83854

Catherine Brooks