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: 04/04/2013

State of Idaho
CERTIFICATE OF DEATH

STATE FILE NO. 2013--03151

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR WITH THE DEPARTMENT OF HEALTH AND WELFARE RAISED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH UNDER §39-3119(4) AND §39-274, IDAHO CODE

Local Reg. No.

DECEDENT — TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN — FOR INSTRUCTIONS SEE HANDBOOKS

MORTICIAN: Complete/Verify and File Within 5 Days of Death

* 1.DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix)	DARLENE A. BAIRD
2. SEX	FEMALE
3. SOCIAL SECURITY NUMBER	518-70-5189
4a. AGE-Last Birthday (Years)	72
4b. UNDER 1 YEAR (Months, Days, Hours, Minutes)	
4c. UNDER 1 DAY	
5. DATE OF BIRTH (Mo/Day/Yr)	09/20/1940
6. BIRTHPLACE (City and State, Territory, or Foreign Country)	BLACKFOOT, IDAHO
7a. RESIDENCE - STATE OR FOREIGN COUNTRY	IDAHO
7b. COUNTY	POWER
7c. CITY OR TOWN	AMERICAN FALLS
7d. STREET AND NUMBER	2366 FAIRVIEW ROAD
7e. APT. NO.	
7f. ZIP CODE	83211
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)	RICHARD DEE BAIRD

PARENTS

10. EVER IN U.S. ARMED FORCES?	☐ Yes ☒ No
11a. FATHER'S NAME (First, Middle, Last, Suffix)	ERWIN ALTON ALLEN
11b. BIRTHPLACE (State, Territory, or Foreign Country)	UTAH
12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)	IDONA ISOLENE TOLMAN
12b. BIRTHPLACE (State, Territory, or Foreign Country)	IDAHO

INFORMANT

13a. INFORMANT'S NAME (Type or print)	RICHARD DEE BAIRD
13b. RELATIONSHIP TO DECEDENT	HUSBAND
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)	2366 FAIRFIEW AMERICAN FALLS, ID 83211

DISPOSITION

* 14. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from Idaho ☐ Other (Specify)
16. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place)	GROVE CITY CEMETERY 1 WILLOW DRIVE BLACKFOOT, IDAHO 83221
* 18. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY	DAVIS-ROSE MORTUARY 170 IDAHO ST P.O. BOX 413 AMERICAN FALLS, IDAHO 83211-0413
* 17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	ELECTRONICALLY FILED: MATTHEW J. ROSE
* 17b. LICENSE NUMBER (Of licensee)	M1026
18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH?	☐ Yes ☒ No

PLACE OF DEATH

PLACE OF DEATH (19-22)

* 19a. IF DEATH OCCURRED IN A HOSPITAL: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA 4☐ Hospice facility 5☐ Nursing home/Long term care facility

* 19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: 6☒ Decedent's home 7☐ Other (Specify)

* 20.FACILITY NAME (If not facility, give street and number)	2366 FAIRVIEW
* 21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE	AMERICAN FALLS, ID 83211
* 22. COUNTY OF DEATH	POWER

DATE OF DEATH

* 23. DATE OF DEATH (Mo/Day/Yr) (Spell month)	March 27, 2013
24. TIME OF DEATH (24hr)	23:57
25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month)	March 27, 2013
26. TIME PRONOUNCED DEAD (24hr)	23:57

CAUSE OF DEATH

C189

27. CAUSE OF DEATH

PART I. 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.

Approximate Interval: Onset to Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COLON CANCER	5 YEARS
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

28a. WAS AN AUTOPSY PERFORMED?	☐ Yes ☒ No
28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?	☐ Yes ☐ No
29. DID TOBACCO USE CONTRIBUTE TO DEATH?	☐ Yes ☐ Probably ☒ No ☐ Unknown
30. IF FEMALE (Aged 10-54):	☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Not pregnant, but pregnant within 42 days of death ☐ Unknown if pregnant within the past year
31. MANNER OF DEATH	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be determined

CERTIFIER: Complete Within 72 Hours of Death

ITEMS 32-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER)

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. INJURY AT WORK?	☐ Yes ☐ No
36. 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 TYPES(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable

TRANSPORTATION INJURY ONLY	38a. WAS DECEDENT: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)
38b. WHAT SAFETY DEVICES(S) DID DECEDENT USE/EMPLOY?	☐ Seat belt ☐ Child safety seat ☐ Helmet ☐ Air bag ☐ None ☐ Unknown

CERTIFIER

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

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 natural cause(s)/manner 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 stated.

39b. LICENSE NUMBER: M-06270

39c. DATE SIGNED: 4 / 3 / 2013 (MM / DD / YYYY)

Signature and Title of Certifier: MICHAEL L. FRANCISCO, M.D.

* 39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print): MICHAEL L. FRANCISCO, 777 HOSPITAL WAY POCATELLO, ID 83201

REGISTRAR

40a. REGISTRAR'S SIGNATURE: James B. Gidlette

40b. DATE SIGNED: 4 / 4 / 2013 (MM / DD / 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.

DATE ISSUED: APR 04 2013

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

James B. Gidlette
JAMES B. AYDELOTTE
STATE REGISTRAR

PBNCO (Rev) 02/12

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE