

After recording please return to:)
Name: Michael L. Fallis)
Address: 5202 Groom Ave.)
City, State, Zip: Alamo NV. 89001)
Phone: 702 305 3061)
Assessor's)
Parcel Number 010-172-06)



OFFICIAL RECORD
LESLIE BOUCHER, RECORDER

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AFFIDAVIT TERMINATING JOINT TENANCY
Pursuant to NRS 40.525(5) and NRS 111.365

State of NEVADA)
County of LINCOLN)

Michael L. Fallis, being first duly sworn, deposes and states:

- I, the undersigned Affiant, am over the age of 21 years and competent to be a witness as to the matter hereinafter stated. I declare that I have knowledge of the facts stated herein.
- I am Michael Leslie Fallis, the same person named as one of the Grantees named in that certain Joint Tenancy Deed recorded on January 16, 2001, as Document No. 115856, in Book 150, Page(s) 17 & 18, of the Official Records in the Office of the County Recorder in Lincoln County, Nevada.
- The property described in the above-referenced deed is located in Lincoln County, Nevada commonly known as Rachel, and described as follows: All of Lot 6 in Block 1 of the Sun Set Acres Tract NO. 1, being a portion of the NW 1/4 and SW 1/4 of the NE 1/4, of Section 36, T35. R55 E. MDB & M., Lincoln County, Nevada.

4. Lora B. Fallis, (the Decedent) was one of the Grantees named in said Deed, and is the Decedent in the attached certified Death Certificate. The date and place of the Decedent's death are set forth in the death certificate and incorporated herein by this reference.
5. The Decedent was my Mother.
6. This affidavit is made for the purpose of terminating the joint tenancy between myself and the Decedent in the described property, said title now vesting in me Michael Leslie Fallis, as sole owner.

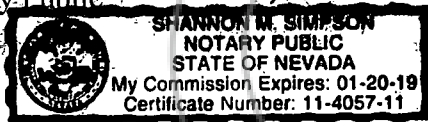
DATED this 24th day of May, 2018.

Michael L. Fallis
Affiant
Michael L. Fallis

State of NV
County of Lincoln

Subscribed and Sworn to before me on this
24th day of May, 2018 by
Michael L. Fallis.

Shannon M. Simpson
Notary Public



STATE OF IDAHO

CERTIFICATION 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 THE DEPARTMENT OF HEALTH AND WELFARE, SHALL BE USED AS PROOF OF FACT. (BY ORDER OF THE GOVERNOR 1993-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020) Local Reg. No.

DECEDENT	1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last, Suffix) LORA BELL FALLIS		2. SEX FEMALE		3. SOCIAL SECURITY NUMBER [REDACTED]	
TYPE OR PERMANENT INK DO NOT USE FELT TIP PEN FOR INSTRUCTIONS SEE HANDBOOKS	4a. AGE, Last Birthday 87 (Years)		4b. UNDER 1 YEAR Months: _____ Days: _____		4c. UNDER 1 DAY Hours: _____ Minutes: _____	
	5. DATE OF BIRTH (Mo/Day/Yr) 12/18/1929		6. BIRTHPLACE (City and State, Territory, or Foreign Country) SHELLEY, IDAHO			
MORTICIAN: Complete, Verify, and File Within 5 Days of Death	7a. RESIDENCE - STATE OR FOREIGN COUNTRY IDAHO		7b. COUNTY BANNOCK		7c. CITY OR TOWN POCATELLO	
	7d. STREET AND NUMBER 1510 JESSIE LANE		7e. APT. NO. 83201		7f. ZIP CODE 83201	
PARENTS	8. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Unknown		9. SURVIVING SPOUSE'S NAME (if wife, give maiden name)			
	10. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11a. FATHER'S NAME (First, Middle, Last, Suffix) CHRIS H. HANSEN		11b. BIRTHPLACE (State, Territory, or Foreign Country) IDAHO	
INFORMANT	12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) CORA JOHNSON		12b. BIRTHPLACE (State, Territory, or Foreign Country) IDAHO		13a. MAILING ADDRESS (Street and Number, City, State, Zip Code) 944 QUINCY STREET IDAHO FALLS, ID 83401	
	13a. INFORMANT'S NAME (Type or print) RICHARD FALLIS		13b. RELATIONSHIP TO DECEDENT SON		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 944 QUINCY STREET IDAHO FALLS, ID 83401	
DISPOSITION	14. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify)		15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place) FIELDING MEMORIAL PARK CEMETERY 4600 SOUTH YELLOWSTONE IDAHO FALLS, IDAHO 83402		16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY WOOD FUNERAL HOME 273 NORTH RIDGE AVENUE IDAHO FALLS, IDAHO 83402	
	17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ELECTRONICALLY FILED: BRIAN T. MCBRIDE		17b. LICENSE NUMBER (of licensee) MT170		18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
PLACE OF DEATH	19a. IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DGA		19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify)		PLACE OF DEATH (19-22)	
	20. FACILITY NAME (if not facility, give street and number) TETON POST ACUTE CARE AND REHABILITATION		21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE IDAHO FALLS, ID 83404		22. COUNTY OF DEATH BONNEVILLE	
DATE OF DEATH	23. DATE OF DEATH (Mo/Day/Yr) (Spell month) October 6, 2017		24. TIME OF DEATH (24hr) 07:30		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) October 6, 2017	
	26. TIME PRONOUNCED DEAD (24hr) 07:30		27. CAUSE OF DEATH			
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: IMMEDIATE CAUSE (Final disease or condition resulting in death): ACUTE HYPOXIC RESPIRATORY FAILURE		DUE TO (or as a consequence of):		Approximate Time Interval: Onset to Death 1 DAY	
	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): SEVERE ACUTE ON CHRONIC ASCITES		DUE TO (or as a consequence of):		3 MONTHS	
ITEMS 22-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER)	29. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		30. IF FEMALE (Aged 10-54): <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 45-90 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Unknown if pregnant within the past year		28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	31. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		32. DATE OF INJURY (Mo/Day/Yr) (Spell month)		33. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
CERTIFIER: Complete Within 72 Hours of Death	34. TIME OF INJURY (24hr)		35. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.)		36. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	37. 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		38. LOCATION OF INJURY: State: _____ City/Town or County: _____ Zip Code: _____ Street and Number or Location: _____ Apartment Number: _____			
CERTIFIER	39a. CERTIFIER (Check only one, based on official capacity for this certificate) <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN ASSISTANT <input type="checkbox"/> ADVANCED PRACTICE REGISTERED NURSE To the best of my knowledge, death occurred at the time, date, and place, and due to the natural cause(s)/manner stated.		39b. WHAT SAFETY DEVICES(D) DID DECEDENT USE/EMPLOY? <input type="checkbox"/> Seat belt <input type="checkbox"/> Child safety seat <input type="checkbox"/> Helmet <input type="checkbox"/> Air bag <input type="checkbox"/> None <input type="checkbox"/> Unknown		39c. LICENSE NUMBER M-12156	
	39c. DATE SIGNED: 10 / 6 / 2017 MM DD YYYY		39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print) ELECTRONICALLY SIGNED: JUDE A. FINK, M.D. JUDE A. FINK, 3100 CHANNING WAY IDAHO FALLS, ID 83404			
REGISTRAR	40a. REGISTRAR'S SIGNATURE <i>James B. Aydelotte</i>		40b. DATE SIGNED 10 / 11 / 2017 MM DD YYYY		40c. SIGNATURE <i>James B. Aydelotte</i>	

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: *October 12 2017* *James B. Aydelotte*
 JAMES B. AYDELOTTE
 STATE REGISTRAR





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STATE OF IDAHO County of Bonneville

This copy of a death certificate was issued by
the District Health Department on behalf of the
Bureau of Vital Records & Health Statistics.

Jane R. Huntz
Local Vital Statistics Registration Official

