

LINCOLN COUNTY, NV

2023-165948

\$37.00

Rec:\$37.00

09/14/2023 10:51 AM

FIRST AMERICAN TITLE INSURANCE COMPANY

OFFICIAL RECORD

AMY ELMER, RECORDER

RECORDING REQUESTED BY

First American Title Insurance
Company of Nevada

**AND WHEN RECORDED
RETURN TO AND MAIL TAX
STATEMENTS TO:**

Dixie F. Brundy
PO Box 312
Fruitland ID
83019

Space Above This Line for
Recorder's Use Only

A.P.N. 003-141-02

File No.: 107-2668032 (TV)

Affidavit - Death of Trustee

State of Nevada)
County of Clark)ss.
)

Dixie F. Brundy ("Declarant") is of legal age, being first duly sworn, deposes and states under penalty of perjury under the laws of the State of Nevada:

1. **Neil Arthur Brundy** ("Decedent") is the person referenced in the attached certified copy of the Certificate of Death who died on **May 18, 2023** at **Boise, ID** (city and state of death).
2. Decedent is the same person named as the trustee named in that certain Declaration of Trust dated **May 13, 2013** executed by **Neil A Brundy and Dixie F. Brundy** as trustor(s) (the "Trust").
3. Decedent as a trustee is the same person who was named as a grantee in that certain **Quit Claim Deed** dated **July 9th 2014** which was recorded as Instrument No. **0146771** in Book **292**, Page **0509**, of Official Records of **Lincoln** County, Nevada as legally described as follows:

Legal Description attached hereto as Exhibit "A" and incorporated herein by this reference

4. Declarant is the successor trustee under the Trust. The Trust was in effect at the date of the death of the Decedent and has not been revoked. Declarant has consented to act as trustee under the Trust.

Dated: 9-12-2023

DECLARANT:

Dixie F. Brundy
Dixie F. Brundy, Trustee

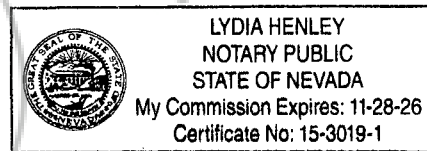
State of Nevada)
)ss
County of Clark)

SUBSCRIBED AND SWORN TO (or affirmed) before me the undersigned, a Notary Public in and for said County Clark and State NV, this 12 day of September, 2023 by Dixie F. Brundy, Trustee, personally know to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me..

WITNESS my hand and official seal.

This area for official notarial seal

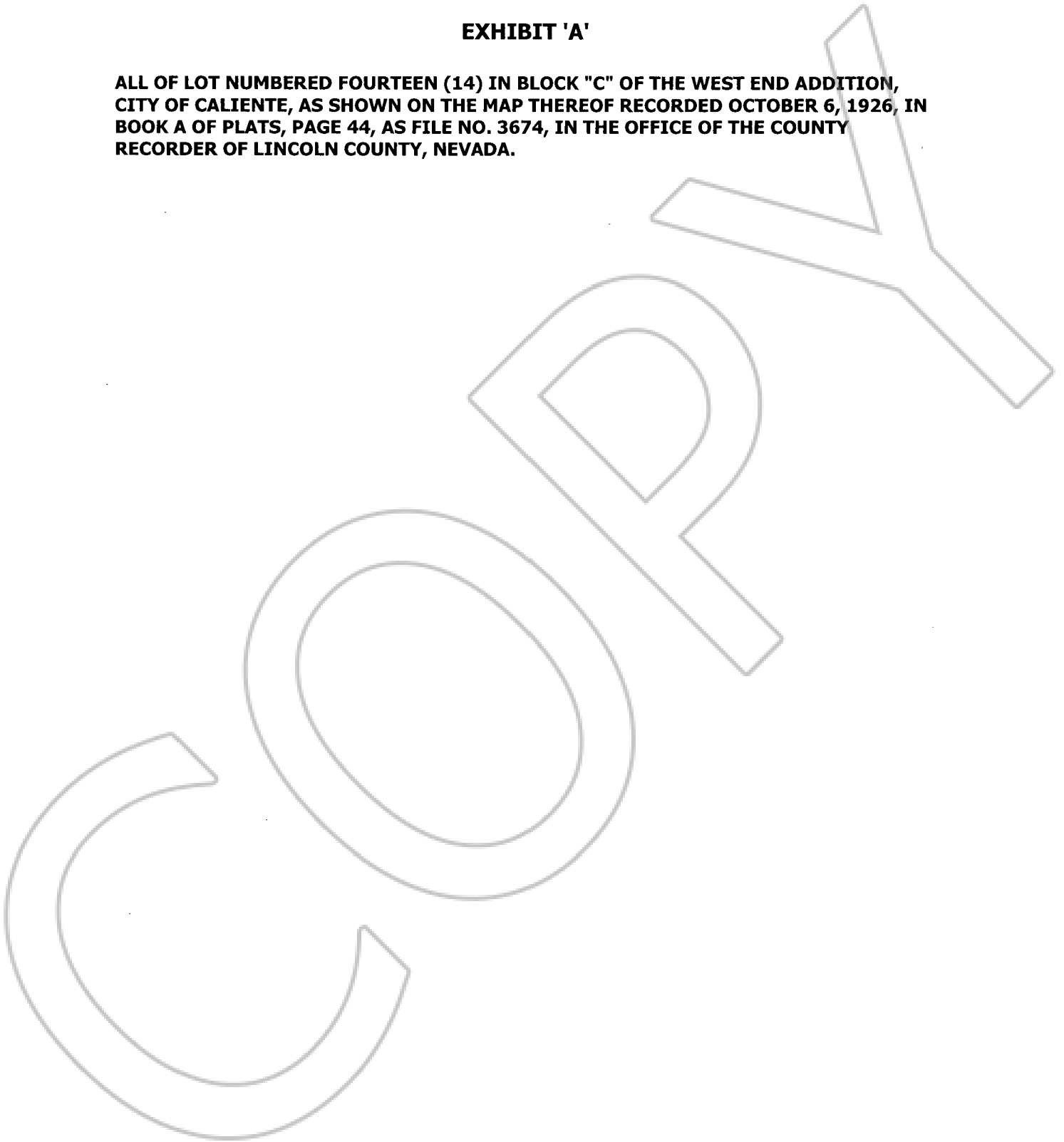
Signature Lydia Henley
My Commission Expires: 11-28-2024



Notary Name: Lydia Henley Notary Phone: 7023212708
Notary Registration Number: 15-3019-7 County of Principal Place of Business NV

EXHIBIT 'A'

**ALL OF LOT NUMBERED FOURTEEN (14) IN BLOCK "C" OF THE WEST END ADDITION,
CITY OF CALIENTE, AS SHOWN ON THE MAP THEREOF RECORDED OCTOBER 6, 1926, IN
BOOK A OF PLATS, PAGE 44, AS FILE NO. 3674, IN THE OFFICE OF THE COUNTY
RECORDER OF LINCOLN COUNTY, NEVADA.**



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 RAISED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH UNDER §30-211(4) AND §30-271. IDAHO CODE Local Reg. No.

DECEDENT	1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last, Suffix) NEIL ARTHUR BRUNDY		2. SEX MALE	3. SOCIAL SECURITY NUMBER [REDACTED]
TYPE OR PRINT IN PERMANENT BLACK INK. DO NOT USE FELT TIP PEN FOR INSTRUCTIONS SEE HANDBOOKS	4a. AGE-Last Birthday 85 (Years)	4b. UNDER 1 YEAR Months: _____ Days: _____	4c. UNDER 1 DAY Hours: _____ Minutes: _____	5. DATE OF BIRTH (Mo/Day/Yr) 12/21/1937
	6. BIRTHPLACE (City and State, Territory, or Foreign Country) CALIENTE, NEVADA		7a. RESIDENCE - STATE OR FOREIGN COUNTRY IDAHO	
	7b. COUNTY PAYETTE		7c. CITY OR TOWN FRUITLAND	
MORTICIAN: Complete/Venify and File Within 5 Days of Death	7d. STREET AND NUMBER 424 S. COLORADO AVE		7e. APT. NO. 83619	7f. ZIP CODE 83619
	7g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		8. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Unknown	
PARENTS	10. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9. SURVIVING SPOUSE'S NAME (if wife, give maiden name) DIXIE MORRISON	
	11a. FATHER'S NAME (First, Middle, Last, Suffix) DAVID NEWTON BRUNDY		11b. BIRTHPLACE (State, Territory, or Foreign Country) NEBRASKA	
INFORMANT	12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) DAGMAR HENRIE		12b. BIRTHPLACE (State, Territory, or Foreign Country) UTAH	
	13a. INFORMANT'S NAME (Type or print) DIXIE BRUNDY		13b. RELATIONSHIP TO DECEDENT SPOUSE	13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) P.O. BOX 312 FRUITLAND, ID 83619
DISPOSITION	14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) ALDEN-WAGGONER CREMATORY 5400 FAIRVIEW AVENUE BOISE, IDAHO 83706	
	16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY ALDEN-WAGGONER FUNERAL CHAPEL 5400 FAIRVIEW AVENUE BOISE, IDAHO 83706		17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ELECTRONICALLY FILED: STEVEN L. GORDON	
PLACE OF DEATH	17b. LICENSE NUMBER (of licensee) M0684		17c. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	19a. IF DEATH OCCURRED IN A HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. <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) _____		19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D.O.A. <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) _____	
DATE OF DEATH	20. FACILITY NAME (if not facility, give street and number) SAINT ALPHONSUS REGIONAL MEDICAL CENTER		21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE BOISE, ID 83706	
	22. COUNTY OF DEATH ADA		23. DATE OF DEATH (Mo/Day/Yr) (Spell month) May 18, 2023	
CAUSE OF DEATH	24. TIME OF DEATH (24hr) 17:05		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) May 18, 2023	
	26. TIME PRONOUNCED DEAD (24hr) 17:05		27. CAUSE OF DEATH	
ITEMS 32-38 TO BE USED FOR EXTERNAL CAUSES ONLY - CORONER	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) a. SUBARACHNOID HEMORRHAGE DUE TO (or as a consequence of) b. RUPTURED CEREBRAL ANEURYSM		Approximate Time Interval Onset to Death 5/18/2023	
	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) c. _____ DUE TO (or as a consequence of) d. _____		Approximate Time Interval Onset to Death 5/18/2023	
CERTIFIER: Complete Within 72 Hours of Death	PART II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. HYPERTENSION; CARDIOGENIC SHOCK		28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	29. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
CLERIFIER	30. IF FEMALE (Aged 10-54): <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 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		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) _____		35. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
REGISTRAR	33. TIME OF INJURY (24hr) _____		34. PLACE OF INJURY (Decedent's home, farm, street, construction site, nursing home, restaurant, forest, etc.) _____	
	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 TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable _____	
IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE	TRANSPORTATION INJURY ONLY <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		38b. WHAT SAFETY DEVICES(S) 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	
	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. <input type="checkbox"/> 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-14120	
Signature and Title of Certifier: ELECTRONICALLY SIGNED: ALVIN P. PERRY III, M.D.		39c. DATE SIGNED 5 / 25 / 2023 MM DD YYYY		
39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print) ALVIN P. PERRY III, 999 N. CURTIS ROAD BOISE, ID 83706		40b. DATE SIGNED 5 / 26 / 2023 MM DD YYYY		
40a. REGISTRAR'S SIGNATURE <i>James B. Galtte</i>		40c. DATE SIGNED 5 / 26 / 2023 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: **MAY 26 2023**

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

James B. Galtte
JAMES B. AYDELOTTE
STATE REGISTRAR

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

