



MOBILE HOME REAL ESTATE EXCISE TAX AFFIDAVIT

Submit to County Treasurer of the county in which property is located.

Chapter 82.45 RCW Chapter 458-61A WAC

This form is your receipt when stamped by cashier.

FOR USE WHEN TRANSFERRING TITLE TO MOBILE HOME ONLY

PLEASE TYPE OR PRINT INCOMPLETE AFFIDAVITS WILL NOT BE ACCEPTED

REGISTERED OWNER: Name Heirs of John P. Smolar, deceased; Street 1316 16th Avenue; City Lewist, State ID, Zip Code 83501. LOCATION OF MOBILE HOME: Name Sonary Crest Mobile Home Park; Street 2015 6th Avenue; City Clarkston, State WA, Zip Code 99403.

NEW REGISTERED OWNER: Name Tracy Yuki; Street 2015 6th Ave, Unit 127 A; City Clarkston, State WA, Zip Code 99403. LEGAL OWNER: Name Tracy Yuki; Street 2015 6th Ave, Unit 127A; City Clarkston, State WA, Zip Code 99403.

PERSONAL PROPERTY PARCEL or ACCOUNT NO. 5-041-35-002-0002-1270 LIST ASSESSED VALUE(S) \$ 14,600

REAL PROPERTY PARCEL or ACCOUNT NO. LIST ASSESSED VALUE(S) \$

Table with columns: MAKE, YEAR, MODEL, SIZE, SERIAL NO. or I.D., REVENUE TAX CODE NO. Row 1: KIT, 1978, 60/24, RGR56H2S6344.

Date of Sale 03/24/2016. Taxable Sale Price \$ 25,000.00. Excise Tax: State \$ 320.00, Local \$ 62.50. Delinquent Interest: State \$ 0.0025, Local \$ 0.0025. Subtotal \$ 382.50. State Technology Fee \$ 5.00. Affidavit Processing Fee \$ . Total Due \$ 387.50.

AFFIDAVIT. I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. Signature of Grantor/Agent Philip Smolar, heir. Date and Place of Signing: 03/24/2016, Clarkston, WA. Signature of Grantee/Agent Tracy Yuki. Date & Place of Signing: 03/24/2016, Clarkston, WA.

TREASURER'S CERTIFICATE. I hereby certify that property taxes due Asotin County on the mobile home described hereon have been paid to and including the year 2016. Date 3/25/16. County Treasurer or Deputy.

If, in selling (or otherwise transferring ownership of) a mobile home which possesses a tax lien, the seller does not inform the buyer (new owner) of such a lien, the seller is guilty of deliberate deception as it applies to Fraud and/or Theft as defined in Title 9 and 9A RCW (RCW 9.45.060, RCW 9A.56.010 (4d), and RCW 9A.56.020).

THIS SPACE - TREASURER'S USE ONLY PAID

ATEC CK # 14751

REV 84 0003e (4/9/08) COUNTY TREASURER

Handwritten initials

ASOTIN COUNTY TREASURER

48183

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 NOT THE DEPARTMENT OF HEALTH AND WELFARE, MAILED SEAL, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH UNDER IDA-24(14) AND IDA-27(4), IDAHO CODE. Local Reg. No.

DECEDENT	1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix): <b>JOHN PAUL SMOLAR</b>		2. SEX <b>MALE</b>	3. SOCIAL SECURITY NUMBER <b>[REDACTED]</b>	
	4a. AGE - Last Birthday <b>88</b> (Year)	4b. UNDER 1 YEAR Months: Days: Hours: Minutes:	4c. UNDER 1 DAY Hours: Minutes:	5. DATE OF BIRTH (Mo/Day/Yr) <b>12/22/1926</b>	6. BIRTHPLACE (City and State, Territory, or Foreign Country) <b>COALDALE, PENNSYLVANIA</b>
MORTICIAN: Complete/Verify and File Within 5 Days of Death	7a. RESIDENCE - STATE OR FOREIGN COUNTRY <b>IDAHO</b>		7b. COUNTY <b>NEZ PERCE</b>	7c. CITY OR TOWN <b>LEWISTON</b>	
	7d. STREET AND NUMBER <b>2870 JUNIPER DR.</b>		7e. APT. NO.: <b>109</b>	7f. ZIP CODE <b>83501</b>	7g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	11a. FATHER'S NAME (First, Middle, Last, Suffix) <b>STEPHEN SMOLAR</b>	11b. BIRTHPLACE (State, Territory, or Foreign Country) <b>AUSTRIA</b>		
INFORMANT	12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) <b>MARY VRABICK</b>		12b. BIRTHPLACE (State, Territory, or Foreign Country) <b>UNKNOWN</b>		
	13a. INFORMANT'S NAME (Type or print) <b>JOHN R SMOLAR</b>	13b. RELATIONSHIP TO DECEDENT <b>SON</b>	13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) <b>1047 12TH ST. CLARKSTON, WA 98403</b>		
DISPOSITION	14. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from Idaho <input type="checkbox"/> Other (Specify)	15. PLACE OF DISPOSITION (Name and address of cemetery, crematory, other place) <b>LEWIS - CLARK MEMORIAL GARDENS 3521 7TH STREET LEWISTON, IDAHO 83501</b>		16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY <b>MOUNTAIN VIEW FUNERAL HOME 3521 SEVENTH STREET LEWISTON, IDAHO 83501</b>	
	17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <b>ELECTRONICALLY FILED: TERESA GATES</b>		17b. LICENSE NUMBER (Of licensee) <b>M1371</b>	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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OCA <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)				
	20. FACILITY NAME (If not facility, give street and number) <b>ST. JOSEPH REGIONAL MEDICAL CTR</b>		21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE <b>LEWISTON, ID 83501</b>		22. COUNTY OF DEATH <b>NEZ PERCE</b>
DATE OF DEATH	23. DATE OF DEATH (Mo/Day/Yr) (Spell month) <b>October 4, 2015</b>		24. TIME OF DEATH (24hr) <b>00:45</b>		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) <b>October 4, 2015</b>
	26. TIME PRONOUNCED DEAD (24hr) <b>00:45</b>		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) a. <b>HYPOXIC AND HYPERCARBIC RESPIRATORY FAILURE</b> DUE TO (or as a consequence of):			Approximate Interval Onset to Death <b>2 WEEKS</b>	
	Sequitentially 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. <b>CONGESTIVE HEART FAILURE AND</b> DUE TO (or as a consequence of): <b>YEARS</b> c. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO (or as a consequence of): <b>YEARS</b> d.				
ITEMS 32-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER)	28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	29. DID TOBACCO USE CONTRIBUTE TO DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input 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 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	
CERTIFIER	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 TYPE(S) OF VEHICLE(S) INVOLVED (Automobile, pickup, motorcycle, ATV, bicycle, etc.) SPECIFY WHICH VEHICLE DECEDENT OCCUPIED, if applicable		
REGISTRAR	38a. WAS DECEDENT: <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 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.		39b. LICENSE NUMBER: <b>M-12393</b>		
REGISTRAR	39c. 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. Signature and Title of Certifier: <b>MAGDALENA GREENE, M.D.</b>		39c. DATE SIGNED <b>10 / 8 / 2015</b> MM DD YYYY		
	39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print) <b>MAGDALENA GREENE, 415 SIXTH STREET LEWISTON, ID 83501</b>		40b. DATE SIGNED <b>10 / 8 / 2015</b> MM DD YYYY		
REGISTRAR	40a. REGISTRAR'S SIGNATURE <i>James B. Aydelotte</i>		40b. DATE SIGNED <b>10 / 8 / 2015</b> 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: OCT 8, 2015

*James B. Aydelotte*  
JAMES B. AYDELOTTE  
STATE REGISTRAR

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

PBNC(7)TRV(1)9211

