



REAL ESTATE EXCISE TAX AFFIDAVIT

This form is your receipt when stamped by cashier.

PLEASE TYPE OR PRINT

CHAPTER 82.45 RCW - CHAPTER 458-61A WAC

THIS AFFIDAVIT WILL NOT BE ACCEPTED UNLESS ALL AREAS ON ALL PAGES ARE FULLY COMPLETED

(See back of last page for instructions)

Check box if partial sale of property

If multiple owners, list percentage of ownership next to name.

Form sections 1, 2, 3: Seller/Grantor (Diane Porter) and Buyer/Grantee (Glenn R. Miller) information, including addresses and tax correspondence details.

Section 4: Street address (145 Big Bear Rd.), location details (unincorporated Asotin County), and legal description of the property.

Section 5: Land Use Code (11 Household, single family units) and tax exemption questions.

Section 6: Designation questions (forest land, current use, special valuation) with YES/NO checkboxes.

Continuance notices (1) and (2) regarding forest land and historic property classification.

Section 7: Signature lines for Deputy Assessor and Owner(s) with PRINT NAME fields.

Section 7: Personal property included in selling price.

Exemption details: WAC No. and Reason for exemption.

Table of financial details: Type of Document (Statutory Warranty Deed), Date (07/05/18), and Selling Price breakdown (Gross \$105,000, Total Due \$1,611.50).

Section 8: Certification of truth and correctness, including signatures of Diane Porter and Glenn R. Miller.

Perjury warning: Perjury is a class C felony punishable by imprisonment or fine.

REV 84 0001a (6/26/14) THIS SPACE - TREASURER'S USE ONLY COUNTY TREASURER

Handwritten notes: ATEC CK# 24122, Va

PAID JUL 06 2018 ASOTIN COUNTY TREASURER

51378

Return Address

Alliance Title & Escrow Corp.
735 5th St.
Clarkston, WA 99403

Please print or type information

Document Title(s) (or transactions contained therein):

1. Death Certificate
- 2.
- 3.
- 4.

Grantor(s) (Last name first, then first name and initials):

1. Porter, Daniel Lee
 - 2.
 - 3.
 - 4.
- Additional names on page ___ of document.

Grantee(s) (Last name first, then first name and initials):

- 1.
 - 2.
 - 3.
 - 4.
- Additional names on page ___ of document.

Legal description (abbreviated: i.e. lot, block, plat or sections, township, range, qtr/rtr.)

Pt of SE ¼ of Sec. 5 / T7N / R45EWM

- Additional legal is on page ___ of document.

Reference Number(s) of Documents assigned or released:

- Additional numbers on page ___ of document.

Assessor's Property Tax Parcel/Account Number

1-056-00-096-0022-0000 and 7-056-00-096-0022-0000

- Property Tax Parcel ID is not yet assigned
 Additional parcel numbers on page ___ of document

The Auditor/Recorder will rely on the information provided on this form. The staff will not read the document to verify the accuracy or completeness of the indexing information.

51378

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, BASED ON THE BEST AVAILABLE EVIDENCE OF THIS DEATH UNDER §§ 34-10 AND §§ 34-27, SHALL BE USED AS PROOF OF THIS DEATH.

Local Reg. No.

DECEDENT	1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last, Suffix) DANIEL LEE PORTER		2. SEX MALE		3. SOCIAL SECURITY NUMBER [REDACTED]	
	4a. AGE - Last Birthday 59 (Years)		4b. UNDER 1 YEAR Months: 08 Days: 24		5. DATE OF BIRTH (Mo/Day/Yr) 08/24/1953	
FOR INSTRUCTIONS SEE HANDBOOKS	7a. RESIDENCE - STATE OR FOREIGN COUNTRY WASHINGTON		7b. COUNTY ASOTIN		7c. CITY OR TOWN CLARKSTON	
	7d. STREET AND NUMBER 1730 13TH STREET		7e. APT. NO.		7f. ZIP CODE 99403	
	8. MARITAL STATUS AT TIME OF DEATH <input 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		9. SURVIVING SPOUSE'S NAME (If wife, give maiden name) DIANE MARIE PETERSON			
PARENTS	10. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11a. FATHER'S NAME (First, Middle, Last, Suffix) HERSHELL L PORTER		11b. BIRTHPLACE (State, Territory, or Foreign Country) MISSOURI	
			12a. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix) MARY CATHERINE STRODE		12b. BIRTHPLACE (State, Territory, or Foreign Country) IDAHO	
INFORMANT	13a. INFORMANT'S NAME (Type or print) DIANE PORTER		13b. RELATIONSHIP TO DECEDENT WIFE		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 1730 13TH STREET CLARKSTON, WA 99403	
DISPOSITION	14. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) MOUNTAIN VIEW CREMATORY 3521 SEVENTH STREET LEWISTON, IDAHO 83501		16. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY MERCHANT FUNERAL HOME 1000 SEVENTH STREET CLARKSTON, WASHINGTON 99403	
	17a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ELECTRONICALLY FILED: GERALD E. BARTLOW		17b. LICENSE NUMBER (Of licensee) M0771		18. WAS CORONER CONTACTED DUE TO CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input 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"/> DCA <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) GREEN FLAT		19b. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <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) GREEN FLAT			
DATE OF DEATH	20. FACILITY NAME (if not facility, give street and number) 48.39417 115.21389		21. CITY, TOWN, OR LOCATION OF DEATH, AND ZIP CODE PIERCE, ID 83546		22. COUNTY OF DEATH CLEARWATER	
	23. DATE OF DEATH (Mo/Day/Yr) (Spell month) August 24, 2012		24. TIME OF DEATH (24hr) 21:15		25. DATE PRONOUNCED DEAD (Mo/Day/Yr) (Spell month) August 25, 2012	
CAUSE OF DEATH	26. TIME PRONOUNCED DEAD (24hr) 03:15		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: IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN CARDIAC DEATH DUE TO (or as a consequence of): b. CORONARY ARTERY DISEASE DUE TO (or as a consequence of): c. DIABETES MELLITUS DUE TO (or as a consequence of): d.			
ITEMS 32-38 TO BE USED FOR EXTERNAL CAUSES ONLY (CORONER)	PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION		29a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		29b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	30. 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"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <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 checked="" type="checkbox"/> No		36. LOCATION OF INJURY: State _____ City/Town or County _____ Zip Code _____ Street and Number or Location _____ Apartment Number _____			
CERTIFIER	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					
	TRANSPORTATION INJURY ONLY: <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)		38a. WAS DECEDENT: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <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	
CERTIFIER	39a. CERTIFIER (Check only one, based on official capacity for this certificate) <input 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 <u>partur</u> cause(s)/manner stated.		39b. LICENSE NUMBER		39c. DATE SIGNED 8 / 29 / 2012 MM DD YYYY	
	<input checked="" 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. Signature and Title of Certifier ELECTRONICALLY SIGNED: WILL RAMBEAU		39d. NAME, ADDRESS, AND ZIP CODE OF CERTIFIER (Type or print) WILL RAMBEAU, P.O. BOX 2605 OROFINO, ID 83544			
REGISTRAR	40a. REGISTRAR'S SIGNATURE <i>James B. Aydelotte</i>		40b. DATE SIGNED 8 / 29 / 2012 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: **AUG 29 2012**

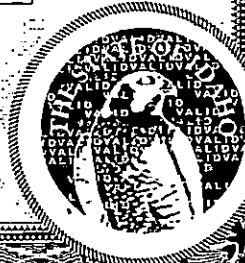
This copy not valid unless prepared on engraved border displaying state seal and signature of the Registrar.

James B. Aydelotte
JAMES B. AYDELOTTE
STATE REGISTRAR

51378

FD-202 (Rev. 8/78)

IN ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE



51378

Local Vital Statistics Registration Official

Paulina Duvst

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

STATE OF IDAHO County of Nez Perce

* 000180723 *

