AFF145,822
05/03/2016

Local File Number:

MONTANA CERTIFICATE OF DEATH

State File Number: 201624-003167

To Be Completed By: Funeral Director

1.DECEDENT'S NAME (First, Middle, Last): Mary Barbara Oliver

AKAs (If Any):

29.ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month): April 27, 2016

2.SEX: Female

Age - last Birthday (Years): 79

4b.Under 1 Year: Months / Days

4c.Under 1 Day: Hours / Minutes

5.DATE OF BIRTH (Month,Day,Year): April 14, 1937

17.COUNTY OF DEATH: Lake

14.PLACE OF DEATH (Check only one)

HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ Dead on Arrival

OTHER: ☐ Nursing Home/Long term care facility ☒ Residence ☐ Hospice ☐ Other

15.FACILITY NAME (If not institution, give street and number): 31815 Sunrise Blvd.

16.CITY,TOWN OR LOCATION OF DEATH: St. Ignatius

6.BIRTHPLACE (City, and State or Foreign Country): St. Ignatius, Montana

9.MARITAL STATUS: ☐ Never Married ☒ Widowed ☐ Married ☐ Married but Separated ☐ Divorced ☐ Unknown

10.SURVIVING SPOUSE:

54.DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.): Cook

55.KIND OF BUSINESS/INDUSTRY: School

8.WAS DECEDENT EVER IN US ARMED FORCES? ☐ Yes ☒ No

7a.RESIDENCE STATE: Montana

7b.COUNTY: Lake

7c.CITY, TOWN, OR LOCATION: St. Ignatius

7d.STREET NUMBER: 31815 Sunrise Blvd.

7f.ZIP CODE: 59865

7g.INSIDE CITY: ☐ Yes ☒ No

51.DECEDENT'S EDUCATION (Specify only the highest diploma or degree received)

- ☐ 8th grade or less
- ☐ 9th-12th grade; No diploma
- ☐ High School graduate or GED completed
- ☒ Some college, but no degree
- ☐ Associates Degree (e.g. AA,AS)
- ☐ Bachelor's Degree (e.g. BA,AB,BS)
- ☐ Master's Degree (e.g. MA,MS,Meng,Med, MSW,MBA)
- ☐ Doctorate (e.g. PhD,EdD) or Professional degree (e.g. MD,DDS,DVM,LLB,JD)

52.DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the No box if the decedent is not Spanish/Hispanic/Latino.)

- ☒ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____

53.DECEDENT'S RACE (Check one or more races to indicate what the decedent considers himself or herself to be.)

- ☐ White
- ☐ Black African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify) _____
- ☒ American Indian or Alaska Native (Name of the enrolled or principal tribe): Salish Kootenai
- ☐ Other (Specify) _____

11.FATHER'S NAME (First, Middle, Last): Stanley J. Oliver

12.MOTHER'S NAME (First, Middle, last name before first marriage): Josephine Cote

13a.INFORMANT'S NAME: Vickie Stinson

13b.RELATION TO DECEDENT: Daughter

13c.MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 1181 , Wallace, Idaho 83873

18.METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other _____

19.PLACE OF DISPOSITION: Mission Valley Crematory

20.LOCATION (City or Town, State): Ronan, Montana

22.SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER PERSON IN CHARGE OF DISPOSITION: Mike Thompson

23.MONTANA LICENSE NO (of licensee if applicable): 367

21.NAME AND ADDRESS OF FUNERAL FACILITY: Shrider - Thompson Funeral & Cremation Service, 419 Round Butte Rd W., Ronan, Montana 59864

To Be Completed By: Medical Certifier

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH

24.DATE PRONOUNCED DEAD (Month/Day/Year): April 27, 2016

25.TIME PRONOUNCED DEAD: 23:30 Military

26.SIGNATURE OF PERSON PRONOUNCING DEATH (only when applicable): Victor M. Davis, MD

27.LICENSE NUMBER: 6402

28.DATE SIGNED (Month/Day/Year): April 28, 2016

30.ACTUAL OR PRESUMED TIME OF DEATH: 23:30 Military Approximate

31.WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☒ Yes ☐ No

CAUSE OF DEATH (See instructions and example)

32. 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. Add additional lines if necessary.

		Approximate interval: (Include Min. Hr. Day, Yrs, etc.)
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COPD	40 years
	DUE TO (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING	b. Tabacco Use Disorder	years
	DUE TO (or as a consequence of):	
CAUSE (disease or injury that initiated the events resulting in death) LAST.	c.	
	DUE TO (or as a consequence of):	
	d.	

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

33.WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No

34.WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH ☐ Yes ☐ No

37.MANNER OF DEATH: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be Determined

35.DID TOBACCO USE CONTRIBUTE TO DEATH? ☒ Yes ☐ Probably ☐ No ☐ Unknown

36.IF FEMALE

- ☐ Not pregnant within past year
- ☐ Not pregnant, but pregnant within 42 days of death
- ☐ Not pregnant, but pregnant 43 days to 1 year before death
- ☐ Pregnant at time of death
- ☐ Unknown if pregnant within past year

DATE OF INJURY (Month,Day,Year) 38.

TIME OF INJURY 39.

INJURED AT WORK 41. ☐ Yes ☐ No

40.PLACE OF INJURY (e.g. Decedent's Home, Construction Site, Restaurant, Wooded Area)

44.IF TRAFFIC ACCIDENT SPECIFY ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other _____

43.DESCRIBE HOW INJURY OCCURRED

42.LOCATION (Street and Number or Rural Route, City, Town, State, Zip Code)

45.TO BE COMPLETED BY CERTIFIER: (A certifier can be a MD, PA, APRN, or coroner)

- ☐ Certifying Physician: To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) and manner stated.
- ☒ Pronouncing & Certifying physician: To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) and manner stated.
- ☐ Medical Examiner/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 Victor M. Davis

49.DATE CERTIFIED (Month,Day,Year): April 28, 2016

48.LICENSE NO: 6402

47.TITLE: MD

46.NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR CORONER): Victor M. Davis, Box 679 , St. Ignatius, MT 59865

LOCAL REGISTRAR'S NAME: Janet Munn

50.DATE FILED (Mo/Day/Yr): April 29, 2016