AFF145,477
03/24/2016

Local File Number:

MONTANA CERTIFICATE OF DEATH

State File Number: 201632-002053

To Be Completed By: Funeral Director

1.DECEDENT'S NAME (First, Middle, Last): John Charles Coots		AKAs (If Any):					29.ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month): March 19, 2016
2.SEX: Male		Age - last Birthday (Years): 79	4b.Under 1 Year Months / Days		4c.Under 1 Day Hours / Minutes		5.DATE OF BIRTH (Month,Day,Year): August 29, 1936
17.COUNTY OF DEATH: Missoula							

14.PLACE OF DEATH (Check only one)
HOSPITAL: [X] 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)	16.CITY,TOWN OR LOCATION OF DEATH
Community Medical Center	Missoula

6.BIRTHPLACE (City, and State or Foreign Country)	9.MARITAL STATUS	10.SURVIVING SPOUSE
Chicago, Illinois	[ ] Never Married [X] Widowed [ ] Married [ ] Married but Separated [ ] Divorced [ ] Unknown	

54.DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	55.KIND OF BUSINESS/INDUSTRY	8.WAS DECEDENT EVER IN US ARMED FORCES?
Auto Mechanic	Automobile	[X] Yes [ ] No

7a.RESIDENCE STATE	7b.COUNTY	7c.CITY, TOWN, OR LOCATION	7d.STREET NUMBER	7f.ZIP CODE	7g.INSIDE CITY
Montana	Ravalli	Stevensville	306 N. Kootenai Creek Rd.	59870	[ ] Yes [X] No

51.DECEDENT'S EDUCATION (Specify only the highest diploma or degree received)
[X] 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.)
[X] 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.)
[X] 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) _____
[ ] Other (Specify) _____

11.FATHER'S NAME (First, Middle, Last)	12.MOTHER'S NAME (First, Middle, last name before first marriage)
Edward Coots	Helen Anderson

13a.INFORMANT'S NAME	13b.RELATION TO DECEDENT	13c.MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jackie Schipporeit	Daughter	20184 King Road , Florence, Montana 59833

18.METHOD OF DISPOSITION	19.PLACE OF DISPOSITION	20.LOCATION (City or Town, State
[ ] Burial [X] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other _____	Daly-Leach Crematory	Hamilton, Montana

22.SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER PERSON IN CHARGE OF DISPOSITION	23.MONTANA LICENSE NO (of licensee if applicable)	21.NAME AND ADDRESS OF FUNERAL FACILITY
Bill Rothie	536	Whitesitt Funeral Home, 314 Church St., Stevensville, Montana 59870

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)	25.TIME PRONOUNCED DEAD
	March 19, 2016	19:00 Military

26.SIGNATURE OF PERSON PRONOUNCING DEATH (only when applicable)	27.LICENSE NUMBER
Travis Leon Bolton, MD	12208

28.DATE SIGNED (Month/Day/Year)	30.ACTUAL OR PRESUMED TIME OF DEATH	31.WAS MEDICAL EXAMINER OR CORONER CONTACTED?
March 19, 2016	19:00 Military Actual	[ ] Yes [X] 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. Septic Shock	2 days
	DUE TO (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.	b. Metastatic Anal Cancer	Unknown
	DUE TO (or as a consequence of):	
	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 [X] No

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

37.MANNER OF DEATH	35.DID TOBACCO USE CONTRIBUTE TO DEATH?	36.IF FEMALE
[X] Natural [ ] Homicide [ ] Accident [ ] Pending Investigation [ ] Suicide [ ] Could not be Determined	[ ] Yes [X] Probably [ ] No [ ] Unknown	[ ] 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.
[X] 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 Travis Leon Bolton

49.DATE CERTIFIED (Month,Day,Year): March 19, 2016

48.LICENSE NO: 12208

47.TITLE: MD

46.NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR CORONER)	LOCAL REGISTRAR'S NAME	50.DATE FILED (Mo/Day/Yr)
Travis Leon Bolton 2827 Fort Missoula Rd , Missoula, MT 59804	Shyra Scott	March 23, 2016