# MONTANA CERTIFICATE OF DEATH

State File Number: 202547-006864

**To Be Completed By: Funeral Director**

DECEDENT'S NAME (*First, Middle, Last*): NARVEL BRANDON BLACKSTOCK

AKA'S If Any:

| 2. Sex | 3. SOCIAL SECURITY NUMBER | 4a. Age – Last Birthday (*Years*) | 4 b. Under 1 Year (Months / Days) | 4c. Under 1 Day (Hours / Minutes) | 5. DATE OF BIRTH (Month, Day, Year) | 29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month) |
|---|---|---|---|---|---|---|
| MALE | [redacted] | 48 | | | DECEMBER 16, 1976 | AUGUST 07, 2025 ACTUAL |

14. PLACE OF DEATH (*Check only one*)
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ Dead on Arrival
OTHER: ☐ Nursing Home/Long term care facility ☒ Residence ☐ Hospice ☐ Other (Specify)

| 15. FACILITY NAME (*If not institution, give street and number*) | 16. CITY, TOWN OR LOCATION OF DEATH | 17. COUNTY OF DEATH |
|---|---|---|
| [redacted] | BUTTE | SILVER BOW |

| 6. BIRTHPLACE (City, and State or Foreign Country) | 9. MARITAL STATUS | 10. SURVIVING SPOUSE (If wife, give last name before first marriage) |
|---|---|---|
| FORT WORTH, TEXAS | ☐ Never Married ☐ 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 U. S. ARMED FORCES? |
|---|---|---|
| RODEO PRODUCER | RODEO | ☐ Yes ☒ No |

| 7a. RESIDENCE- State | 7b. COUNTY | 7c. CITY, TOWN, OR LOCATION | 7d. STREET NUMBER | 7f. ZIP CODE | 7g. INSIDE CITY LIMITS |
|---|---|---|---|---|---|
| MONTANA | SILVER BOW | BUTTE | [redacted] | [redacted] | ☐ 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 decedents 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)
- ☐ Other (Specify)

| 11. FATHER'S NAME (First, Middle, Last) | 12. MOTHER'S NAME (First, Middle, last name before first marriage) |
|---|---|
| NARVEL BLACKSTOCK | ELISA GAYLE RITTER |

| 13a. INFORMANT'S NAME | 13b. RELATIONSHIP TO DECEDENT | 13c. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|---|
| NARVEL BLACKSTOCK | FATHER | 30 [redacted] |

| 18. METHOD OF DISPOSITION | 19. PLACE OF DISPOSITION (Name of Cemetery, crematory, or other place) | 20. LOCATION –City or Town, State |
|---|---|---|
| ☐ Burial ☒ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) | BUTTE CREMATORIES INC | BUTTE, MONTANA |

| 22.SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER PERSON IN CHARGE OF DISPOSITION | 23. MONTANA LICENSE NUMBER (of licensee if applicable) | 21. NAME AND ADDRESS OF FUNERAL FACILITY |
|---|---|---|
| /e/ HALEY ESSENHEIMER | 6646 | AXELSON FUNERAL AND CREMATION SERVICES 2009 HARRISON AVE BUTTE, MONTANA 59701 |

**Blue to be completed by Pronouncing & Certifying Physician or Medical Examiner/Coroner**

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

| 24. DATE PRONOUNCED DEAD (Mo/Day/Year) | 25. TIME PRONOUNCED DEAD |
|---|---|
| 08/07/2025 | 11:13 AM |

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)

27. LICENSE NUMBER

| 28. DATE SIGNED (Mo/Day/Year) | 30. ACTUAL OR PRESUMED TIME OF DEATH | 31. WAS MEDICAL EXAMINER OR CORONER CONTACTED? |
|---|---|---|
| 08/13/2025 | 11:13 MILITARY | ☐ Yes ☒ No |

**CAUSE OF DEATH (See instructions and examples)**

32. PART I Enter the chain of events --disease, injuries, or complications-- that directly caused the death. DO NOT enter terminal events such as cardiac or respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on each line. Add additional lines if necessary

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (final disease or Condition resulting in death) | a. MALIGNANT MELANOMA | 3 YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions if any, leading to cause listed on line a. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death.) **Last** | b | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part 1
SEIZURES

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☒ No

34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH ☐ Yes ☐ No NOT APPLICABLE

| 37. MANNER OF DEATH | 35. DID TOBACCO USE CONTRIBUTE TO DEATH? | 36. IF FEMALE: |
|---|---|---|
| ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could not be Determined | ☐ Yes ☐ Probably ☐ No ☒ Unknown | ☐ Not pregnant within past year ☐ Pregnant at time of death ☐ Not pregnant but pregnant with 42 days of death ☐ Unknown if pregnant within past year ☐ Not pregnant but pregnant 43 days to 1 year before death |

| 38. DATE OF INJURY (Month, Day, Year) | 39. TIME OF INJURY | 41. INJURY AT WORK | 40. PLACE OF INJURY (E.g. Decedent's Home, Construction Site, Restaurant, wooded area) | 44. IF TRAFFIC ACCIDENT SPECIFY |
|---|---|---|---|---|
| | | ☐ Yes ☐ No | | ☐ Driver/Operator ☐ Pedestrian ☐ Passenger ☐ Other (specify) |

43. DESCRIBE HOW INJURY OCCURRED

42. LOCATION (Street and Number or Rural Route Number, 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 cause(s) and manner stated
- ☐ Pronouncing and Certifying Physician: To the best of my Knowledge death occurred at the time, date, and place and due to cause(s) and manner stated.
- ☐ Medical Examiner/Coroner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and place and due to the cause(s) and manner stated.

SIGNATURE /e/ JENIFER DODGE, MD

49. DATE CERTIFIED (Month, Day, Year): 08/13/2025

| 48. LICENSE NUMBER | 47. Title |
|---|---|
| 9959 | MD |

| 46. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR CORONER) (Type or Print) | LOCAL REGISTRAR'S NAME | 50. DATE FILED (Month, Day, Year) |
|---|---|---|
| [redacted] | CINDY SHERMAN | 08/14/2025 |