DOUGLAS COUNTY, NV
Rec:$40.00
Total:$40.00
HERITAGE LAW

2023-1001953
11/02/2023 04:19 PM
Pgs=13

00174442202310019530130130

SHAWNYNE GARREN, RECORDER

APN# 1420-28-402-001

Recording Requested by/Mail to:

Name: HERITAGE LAW

Address: 1625 SR 88, Suite 304

City/State/Zip: Minden NV 89423

Mail Tax Statements to:

Name: Steven Fanning, Trustee

Address: 2801 Wildhorse Lane

City/State/Zip: Minden NV 89423

Certification of Trust

Title of Document (required)

Please complete the Affirmation Statement below:

The undersigned hereby affirms that the document submitted for recording DOES contain personal information as required by law: (check applicable)

☐ **Affidavit of Death** – NRS 440.380 (1)(A) & NRS 40.525 (5) ☐ **Military Discharge** – NRS 419.020 (2)

☑ **Other** NRS 603A.040 (state specific law)

-OR-

☐ I the undersigned hereby affirm the attached document, including any exhibits, hereby submitted for recording does NOT contain the personal information of any person(s). (Per NRS 239B.030)

Signature

DANIELLE CHRISTENSEN

Printed Name

This document is being (re-)recorded to correct document #_____, and is correcting

_____

_____

_____.

Certification of Trust

for the Fanning Family Trust,

dated September 29, 2022, and any amendments thereto

Pursuant to Nevada Revised Statutes Title 13, Chapter 164.400 et al., this Certification of Trust is signed by the currently acting Trustee of the *Fanning Family Trust, dated September 29, 2022*, and any amendments thereto, who declares:

1. The Grantors and Trustees of the trust are THOMAS L FANNING and HELEN E. FANNING.

2. HELEN E. FANNING passed away on October 13, 2023. A true and correct color copy of the Nevada Certificate of Death for HELEN E. FANNING is attached as **Exhibit 1** and is incorporated herein by this reference. A certified Nevada Certificate of Death is available for inspection upon request.

3. Grantor THOMAS L FANNING was diagnosed with Dementia with Behavioral Disturbances since before 2019 and, more recently, Dr. Sophia Ji Hye Kim, Nevada Licensed Physician with the State of Nevada Veteran's Home, completed a *Physician's Certificate with Needs Assessment* dated October 27, 2023, in which THOMAS L. FANNING's mental diagnosis is stated as, "Dementia – CM F 02.81." The completed *Physician's Certificate with Needs Assessment* was delivered to the nominated Successor Trustee, STEVEN FANNING, on the same date (October 27, 2023). A true and correct copy of the *Physician's Certificate with Needs Assessment* dated October 27, 2023, is attached hereto as **Exhibit 2** and is incorporated herein by this reference. The original *Physician's Certificate with Needs Assessment* dated October 27, 2023, and signed by Dr. Kim, is available for inspection upon request.

4. Article IX, Paragraph E, "Inability of Grantor-Trustee to Perform Duties as Trustee," provides that the "…Grantor shall cease to be a Trustee of this Trust if the Grantor lacks the ability to perform the duties of the Trustee. The Grantor shall be conclusively presumed to lack the ability to perform the Trustee's duties when the Grnator's doctor declares in an executed written declaration under penalty of perjury that in their opinion the Grantor does not have sufficient understanding or ability to perform the duties of the Trustee, and when such declaration has been delivered to the Successor Trustee."

   The completion and delivery of the *Physician's Certificate with Needs Assessment* dated October 27, 2023, complies with Article IX, Paragraph E, of the trust, and surviving Grantor THOMAS L. FANNING has been determined to lack the ability to perform the duties of the Trustee.

5. The successor Trustee(s) of the trust upon the incapacity and/or death of a Grantor(s) is/are:

   STEVEN FANNING, then

   HOPE MESSATZZIA

6. Title to assets held in the trust during the surviving Grantor's incapacity will be titled as:

   Steven Fanning, Trustee of the Fanning Family Trust, dated September 29, 2022, and any amendments thereto.

7. The tax identification number of the trust is the Social Security number of THOMAS L FANNING.

8. An alternative description will be effective to title assets in the name of the trust or to designate the trust as a beneficiary if the description includes the name of at least one initial or Successor Trustee, any reference indicating that property is being held in a fiduciary capacity, and the date of the trust.

9. Excerpts from the trust document that establish the trust, designate the Trustee, and set forth the powers of the Trustee will be provided upon request. The powers of the Trustee include the power to acquire, sell, assign, convey, pledge, encumber, lease, borrow, manage, and deal with real and personal property interests.

10. The terms of the trust provide that a third party may rely upon this Certification of Trust as evidence of the existence of the trust and is specifically relieved of any obligation to inquire into the terms of this trust or the authority of the Trustee, or to see to the application that the Trustee makes of funds or other property received by the Trustee.

10. The trust has not been revoked, modified, or amended in any way that would cause the representations in this Certification of Trust to be incorrect.

DATED: November 1, 2023.

STEVEN FANNING,
Successor Trustee during Incapacity of Surviving
Grantor THOMAS L. FANNING

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

This document was subscribed and sworn to before me, a Notary Public, on November 1, 2023, by STEVEN FANNING.

Notary Public

NOTARY PUBLIC
STATE OF NEVADA
of Douglas County
SUSAN C. HAPPE
02-73453-5
My Appointment Expires February 15, 2026

EXHIBIT 1

Fanning Family Trust,
dated September 29, 2022, and any amendments thereto

Color Copy, Nevada Certificate of Death, HELEN E. FANNING

STATE OF NEVADA
CERTIFICATION OF VITAL RECORD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
VITAL STATISTICS

CASE FILE NO. 4375546

CERTIFICATE OF DEATH

2023022643
STATE FILE NUMBER

DECEDENT

1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX)			2. DATE OF DEATH (Mo/Day/Year)	3a. COUNTY OF DEATH
Helen	Esther	FANNING	October 13, 2023	Douglas

3b. CITY, TOWN, OR LOCATION OF DEATH	3c. HOSPITAL OR OTHER INSTITUTION -Name(If not either, give street and number)	3e.If Hosp. or Inst. indicate DOA,OP/Emer. Rm. Inpatient(Specify)	4. SEX
Minden	2801 Wildhorse Lane	Home	Female

5. RACE (Specify)	6. Hispanic Origin? Specify No - Non-Hispanic	7a. AGE-Last birthday (Years)	7b. UNDER 1 YEAR MOS / DAYS	7c. UNDER 1 DAY HOURS / MINS	8. DATE OF BIRTH (Mo/Day/Yr)
White		89			December 31, 1933

IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

9a. STATE OF BIRTH (If not US/CA, name country)	9b. CITIZEN OF WHAT COUNTRY	10.EDUCATION	11. MARITAL STATUS (Specify)	12. SURVIVING SPOUSE'S NAME (Last name prior to first marriage)
Pennsylvania	UNITED STATES	12	Married	Thomas L FANNING

13. SOCIAL SECURITY NUMBER	14a. USUAL OCCUPATION (Give Kind of Work Done During Most of	14b. KIND OF BUSINESS OR INDUSTRY	Ever in US Armed Forces?
[redacted]-9477	Data Processor	Data Processor	No

15a. RESIDENCE - STATE	15b. COUNTY	15c. CITY, TOWN OR LOCATION	15d. STREET AND NUMBER	15e. INSIDE CITY LIMITS (Specify Yes or No)
Nevada	Douglas	Minden	2801 Wildhorse Lane	No

PARENTS

16. FATHER/PARENT - NAME (First Middle Last Suffix)	17. MOTHER/PARENT - NAME (First Middle Last Suffix)
Clyde BROWN	Hope ABRAHMS

18a. INFORMANT- NAME (Type or Print)	18b. MAILING ADDRESS (Street or R.F.D. No, City or Town, State, Zip)
Hope MESSATZZIA	2801 Wildhorse Lane Minden, Nevada 89423

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	19b. CEMETERY OR CREMATORY - NAME	19c. LOCATION City or Town State
Cremation	Walton's Sierra Crematory	Carson City Nevada 89706

20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such)	20b. FUNERAL DIRECTOR LICENSE NUMBER	20c. NAME AND ADDRESS OF FACILITY
BLAKE HOWE SIGNATURE AUTHENTICATED	FD622	Cremation Society of Nevada - Capitol City 1614 N Curry Street Carson City NV 89703

TRADE CALL

TRADE CALL - NAME AND ADDRESS

CERTIFIER

To Be Completed by CERTIFYING PHYSICIAN

21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.(Signature & Title) SIGNATURE AUTHENTICATED
JOSEPH W HEFLIN JR MD

21b. DATE SIGNED (Mo/Day/Yr)	21c. HOUR OF DEATH
October 17, 2023	13:50

21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To Be Completed by CORONER'S OFFICE

22a. 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) stated. (Signature & Title)

22b. DATE SIGNED (Mo/Day/Yr)	22c. HOUR OF DEATH

22d. PRONOUNCED DEAD (Mo/Day/Yr)	22e. PRONOUNCED DEAD AT (Hour)

23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print)	23b. LICENSE NUMBER
Joseph W Heflin Jr MD 1600 Medical Parkway Carson City, NV 89703	15218

REGISTRAR

24a. REGISTRAR (Signature)	24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)	24c. DEATH DUE TO COMMUNICABLE DISEASE
MARLI MORAIGNE REINHEIMER SIGNATURE AUTHENTICATED	October 18, 2023	YES ☐ NO ☒

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST >

25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

		Interval between onset and death
PART I (a)	Neoplasm Brain	
	DUE TO, OR AS A CONSEQUENCE OF:	Interval between onset and death
(b)	Primary Breast Cancer	
	DUE TO, OR AS A CONSEQUENCE OF:	Interval between onset and death
(c)	Metastatic Disease	
	DUE TO, OR AS A CONSEQUENCE OF:	Interval between onset and death
(d)		

PART II OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part 1.	26. AUTOPSY (Specify Yes or No)	27. WAS CASE REFERRED TO CORONER (Specify Yes or No)
	No	No

28a. ACC., SUICIDE, HOM., UNDET. OR PENDING INVEST. (Specify)	28b. DATE OF INJURY (Mo/Day/Yr)	28c. HOUR OF INJURY	28d. DESCRIBE HOW INJURY OCCURRED

28e. INJURY AT WORK (Specify Yes or No)	28f. PLACE OF INJURY- At home, farm, street, factory, office building, etc. (Specify)	28g. LOCATION STREET OR R.F.D. No.	CITY OR TOWN	STATE

CERTIFIED COPY OF VITAL RECORDS

This is a true and exact reproduction of the document officially registered and placed on file in the office of the State Registrar and Vital Records.

DATE ISSUED: 10/18/2023

STATE REGISTRAR

This copy is not valid unless prepared on engraved border displaying date, seal and signature of Registrar.

THE GREAT SEAL OF THE STATE OF NEVADA

STATE OF NEVADA OFFICE of the STATE REGISTRAR and VITAL RECORDS DEPARTMENT OF HEALTH AND HUMAN SERVICES

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EXHIBIT 2

Fanning Family Trust,
dated September 29, 2022, and any amendments thereto

Copy, Physician's Certificate with Needs Assessment dated October 27, 2023, executed by Dr. Sophia Ji Hye Kim and concerning surviving Grantor THOMAS L. FANNING

PHYSICIAN'S CERTIFICATE WITH NEEDS ASSESSMENT

*(Please answer **all** questions)*

I, SOPHIA JI HYE KIM, am qualified to complete this form because:
Physician's Full Name (please print legibly)

(☒ *check one*)

- ☐ I am a physician licensed to practice in the State of Nevada.
- ☒ I am a physician employed by the Department of Veterans Affairs.
- ☐ I am employed by the following Nevada governmental agency that conducts investigations* (*agency name*): _____.
- ☐ I am a person who is otherwise qualified to execute this certificate (subject to the court's determination).* My qualifications are as follows:

_____

_____

SECTION 1: Examination Information, Diagnosis and Condition

I last examined Thomas L Fanning, an adult, on 6-12-23,
Patient's Full Name ("Patient") *Date of Exam*

at 2801 Wildhorse Ln, Minden, NV. I have been the Patient's physician
Name of Facility or Address of Office or Residence

since 6-3-20; Patient (☒ *check one*) ☐ is / ☒ is not under my continuing care/treatment.
Date of First Encounter

A. Prior to the examination, I informed the Patient that my communications with him or her **would not be privileged:** ..... (☒ *check one*) ☒ Unable to Comprehend ☐ Yes ☐ No

B. In addition to examining the Patient, I reviewed the following documents: Dementia + his behaviors.

_____

_____

C. I (☒ *check one*) ☒ AM / ☐ AM NOT aware of the existence of a healthcare directive, living will, power of attorney, guardian nomination, or other similar document executed by the Patient.

If you ARE aware of such a document, provide additional information *(location of document, identity of designated agent, etc.)*: Family has copy / VA has copy.
Hope Messatzzia 775-267-9149

_____

D. Was the Patient given or diagnosed using any generally accepted cognitive assessment exam or tool, including but not limited to Folstein's mini-mental status exam? If YES, please attach a copy. ..... ☐ Yes ☒ No

* Before the court can appoint a guardian, a licensed physician must complete an assessment of the Patient's needs that identifies limitations of capacity and how such limitations affect the Patient's ability to maintain safety and basic needs.

E. The Patient's **physical diagnosis** (DSM or ICD Diagnoses) and condition is:
Dementia - CM F02.81
Hypertension - CM I10

Prognosis is: progressing

Severity/Degree is: (☒ *check one*) ☐ Mild ☒ Moderate ☐ Severe

F. The Patient's **mental diagnosis** (DSM or ICD Diagnoses) and condition is:
Dementia - CM F 02.81

Prognosis is: progressing

Severity/Degree is: (☒ *check one*) ☐ Mild ☒ Moderate ☐ Severe

G. Which of the following descriptions apply to the patient's degree of cognitive impairment (☒ *check all that apply*)?

- ☒ The patient has a ☒ sufficient loss or ☐ total loss of executive function resulting in a barrier to meaningful understanding or rational response.
- ☐ The Patient is able to make independently some but not all of the decisions necessary for his or her own care and management of property.
- ☐ The patient is unable to execute on desires, preferences, or stated goals, preventing the ability to pursue the patient's own best interest.
- ☐ The patient is unable to receive or evaluate information.
- ☐ The patient is unable to make or communicate decisions to such an extent that the patient lacks the ability to meet essential requirements for physical health, safety, or self-care without proper assistance.
- ☐ None of the above.

H. Is the Patient facing an immediate need for medical attention? ..... ☐ Yes ☒ No
If YES, is the Patient unable to respond to the need for medical attention? ..... ☐ Yes ☐ No
If YES, explain the immediate attention needed and why the Patient is unable to respond:

I. Is the Patient facing a substantial and immediate risk of physical harm? ..... ☐ Yes ☒ No
If YES, is the Patient unable to respond to that risk of physical harm? ..... ☐ Yes ☐ No
If YES, explain the immediate risk and why the Patient is unable to respond:

J. Is the Patient facing a substantial and immediate risk of financial loss? ..... ☐ Yes ☒ No
If YES, is the Patient unable to respond to that risk of financial loss? ..... ☐ Yes ☐ No
If YES, explain the immediate risk and why the Patient is unable to respond:

_____

_____

K. Does the Patient present a danger to himself/herself? ..... ☐ Yes ☒ No
Does the Patient present a danger to others? ..... ☐ Yes ☐ No
If YES, explain:

_____

_____

L. Has the Patient been subjected to abuse, neglect, or exploitation? ..... ☐ Yes ☒ No
If YES, explain:

_____

_____

M. Is the Patient capable of living independently? (☒ *check one*)
☐ Yes, without assistance ☐ Yes, with assistance ☒ No
If WITH ASSISTANCE, describe the assistance needed; if NO, explain why not:

_____

_____

N. Attached to this certificate is (☒ *check all that apply, if applicable*):
- ☐ A copy of my report of the above exam which includes my findings, opinion, and diagnosis regarding the Patient and his/her mental condition and/or capacity.
- ☐ A copy of the Patient's chart notes which support and/or detail my findings, opinion, and diagnosis regarding the Patient and his/her mental condition and/or capacity.
- ☒ A letter, signed by me, detailing my findings, opinion, and diagnosis regarding the Patient and his/her mental condition and/or capacity.

SECTION 2: Ability to Appear at Hearing

A. Would the Patient's attendance at a hearing for appointment of a guardian be detrimental to the Patient's mental health? ..... ☐ Yes ☒ No
If YES, why?

_____

_____

B. Would attending the hearing for appointment of a guardian be detrimental to the Patient's physical health? ..... ☐ Yes ☒ No
If YES, why?

_____

_____

C. Is the patient able to appear at a court hearing? ..... ☐ Yes ☒ No
If NO, why not?
Given his level of dementia, he would not understand why he was there.

D. Would the patient comprehend the reason for a hearing? ..... ☐ Yes ☒ No

E. Would the patient contribute to a hearing? ..... ☐ Yes ☒ No

SECTION 3: Limitations, Abilities, and Needs

A. The Patient's level of needed supervision is as follows:
- ☐ Locked Facility
- ☒ 24-hour supervision
- ☐ Independent living with some supervision
- ☐ No supervision
- ☐ No supervision when taking medication

B. My opinion as to the Patient's everyday functions is as follows:

CARE OF SELF (Activities of Daily Living (ADLs) and related activities)	Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	Unknown
Bathe and shower				X	
Personal hygiene and grooming (e.g., brushing teeth, hair)			X		
Dress self				X	
Toilet hygiene (getting to toilet, cleaning self, getting back up)				X	
Functional mobility (e.g., walking, transferring to/from bed or chair)				X	
Feed self and eat for adequate nutrition			X		
Identify physical abuse or neglect and protect self from harm			X		
FINANCIAL					
Manage, deposit, withdraw, dispose of, and invest money and assets				X	
Protect, and spend small amounts of cash				X	
Employ persons to advise or assist him/her				X	
Identify financial exploitation, coercion, undue influence				X	
Protect self from financial exploitation, coercion, undue influence				X	
Give gifts and donations			X		

	Independent	Needs Support	Needs Substantial Assistance	Needs Total Care	Unknown
MEDICAL				X	
Give/withhold medical consent to medical, dental, psychological				X	
Admit self to health facility				X	
Make or change an advance directive or healthcare power of attorney				X	
Manage medications				X	
Contact help if ill or in medical emergency				X	
HOME AND COMMUNITY LIFE					
Choose/establish residence				X	
Maintain reasonably safe and clean shelter				X	
Drive or use public transportation				X	
Prepare food/meals, cleanup				X	
Shop for groceries and necessities				X	
Use telephone or other forms of communication				X	
Make and communicate choices about roommates				X	
Avoid environmental dangers such as stove, poisons				X	
Maintain and pay household bills, utilities, mortgage/rent, taxes				X	

SECTION 4: Civil and Legal

A. In my opinion, the Patient lacks the capacity necessary to (☒ *check all that apply*):
- ☒ Enter into a contract, financial commitment, or lease arrangement
- ☒ Make or modify a will or power of attorney
- ☒ Participate in mediation

B. Is the Patient capable of driving? ..... ☐ Yes ☒ No ☐ Uncertain

C. Would the Patient present a risk or threat to self or others if Patient were to own or purchase a firearm? ..... ☒ Yes ☐ No ☐ Uncertain

D. Does the Patient have the capacity necessary to understand and complete voter registration forms and vote? ..... ☐ Yes ☐ No ☒ Uncertain

SECTION 5: Remarks and Recommendations

A. If you have any remarks concerning other sections, or if you believe the court should be aware of other concerns about the Patient which are not included above, please explain:

Pt since I've known him has relied on his wife, Helen to make decisions for him + he always deferred to her.

B. If you have any recommendations for needed treatment or services which are not included above, please explain:

Since her death, he is unable to understand + make meaningful decisions + relies on his family to make them for him.

(This certificate must be signed by the physician, agency employee, or other person identified at the top of page 1 of the certificate.)

I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct.

Date: October 27, 2023 Signature: [signature] MD

Print Name: Sophia Kim, MD

Address: 1330 Waterloo Ln #101
Gardnerville, NV 89410

Telephone: 775-782-5265

The following psychologist, nurse, nurse practitioner, physicians' assistant, social worker, case manager, or other assisted in completion of this form *(print all names below, if applicable)*:

_____

_____

_____

DEPARTMENT OF VETERANS AFFAIRS
VA Sierra Nevada Health Care System
Providing World Class Care and Service to America's Heroes

In Reply Refer to:

October 27, 2023

To Whom It May Concern,

I am Thomas L Fanning's primary care physician at VA Sierra Nevada Health Care System (VASNHCS).

I have known Thomas and Helen Fanning since I became his primary care physician in June 2020. I've been a geriatrician for over 15 years. He was diagnosed with dementia with behavioral disturbance since before 2019. He had many sleep and behavioral issues, most of which have stabilized. He has slowly progressed and now has limited ability to walk and is motorized wheelchair dependent. Over the years, he was able to make simple decisions, 'I want to eat that; I don't want to eat that', but for all his medical decisions, he always deferred to his wife, Helen. If you asked him about his opinion, he states "I don't know". Unfortunately, this week, I heard of Helen's passing. Prior to her death, care of him at home was too challenging with multiple recurrent falls, and after a short hospitalization, he was transferred to the Northern Nevada Veterans Home in Sparks, NV in August 2023. He currently resides there for 24-hour care. He will not improve from his level of dementia, and I expect him to progress further.

Enclosed is copy of the Durable Power of Attorney for Health Care Decisions that we have a copy in the VA.

Sincerely,

Sophia J. Kim, MD
Reno Home Based Primary Care