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BEFORE THE NEVADA STATE BOARD OF FUNERAL & CEMETERY SERVICES

STATE OF NEVADA

In the Matter of:

Case No. FB24-06 and FB24-16

MCDERMOTT'S FUNERAL AND
CREMATION SERVICE, a Funeral
Establishment, and CHRISTOPHER M.
GRANT, a Funeral Director,

Respondents.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This combined matter was heard by the State of Nevada Board of Funeral and Cemetery Services ("Board") on August 7, 2025, via Zoom videoconference, with Board Chairman Dr. Randy Sharp and Board Members Kim Kandaras, Laura Sussman, Dr. Raymond Giddens, Jr., Reverend Dr. D. Edward Chaney, Jeffery Long, and Celena DiLullo present. Respondent Christopher M. Grant ("GRANT"), a Funeral Director, individually and on behalf of Respondent McDermott's Funeral and Cremation Service ("MCDERMOTT'S"), a Funeral Establishment, (collectively, "RESPONDENTS") appeared *pro se*. The Board Staff and executive Director Stephanie McGee were represented by Deputy Attorney General Matthew Feeley. Senior Deputy Attorney General Todd Wiess provided legal counsel to the Board.

The Formal Complaints for FB24-06 and FB24-16 were both set to be heard at the August 7, 2025, hearing. The Board, pursuant to Nevada Administrative Code (NAC") 642.180(14), joined the two formal complaints finding that the causes of action of each formal complaint are against the same person and deal with substantially the same or similar violations of statutes and regulations, and that the joining of the formal complaints will serve the best interest of the Board, complainant and respondent. The two

1 scheduled hearings were therefore joined into the combined hearing.

2 The Board, having considered the testimony of witnesses, the exhibits introduced at the hearing,
3 together with all papers and pleadings filed with the Board in this matter and pursuant to NAC 642.180(5)
4 and (12), makes the following findings of fact, conclusions of law, and decision.

5 FINDINGS OF FACT

6 1. At all times relevant to the Complaint, McDERMOTT’S held a permit as a Funeral
7 Establishment issued by the Nevada State Board of Funeral & Cemetery Services (“Board”).

8 2. At all times relevant to the Complaint, GRANT held a license as a Funeral Director issued
9 by the Board.

10 3. RESPONDENTS are therefore subject to the jurisdiction of the Board and Board Staff
11 and the provisions of NRS chapters 642, 451, and 452 and NAC chapters 642, 451, and 452.

12 4. Pursuant to NRS 642.5172 through NRS 642.524, NRS 642.130 and NRS 642.135, the
13 Board may take disciplinary action by way of this Complaint.

14 5. At all times relevant to this complaint, GRANT was and is the managing Funeral Director
15 at McDERMOTT’S.

16 6. On November 28, 2023, the Board's inspector, Dr. Wayne Fazzino, conducted an
17 inspection of McDERMOTT'S located at 2121 Western Avenue in Las Vegas.

18 7. On February 21, 2024, the Board's inspector conducted a follow-up inspection of
19 McDERMOTT'S regarding the reinstallation of a preparation room door.

20 8. During this visit, the inspector checked the refrigeration units used by McDERMOTT’S.
21 The inspector reviewed the bodies being stored in the cooler and a list of the decedents maintained by
22 McDERMOTT'S. Based on the review, eight decedents were identified as not being cremated or
23 otherwise disposed of for an extended period of time, including:

24 a. Pamala Middlebrooks,

25 b. Joseph Vocatura,

26 c. Debi Vince,

27 d. Catherine Lane-Novak,

28 e. Lonna Lonning,

- f. Teresa John,
- g. Lawrence Ponteri, and
- h. Edward Elliot.

9. On March 16, 2024, based on the findings of this inspection, Board Executive Director Stephanie McGee filed an Informal Administrative Complaint against RESPONDENTS.

10. On March 18, 2024, Board Executive Director Stephanie McGee sent a Notice of Summary of Informal Complaint (“233B Letter”) to RESPONDENTS.

11. As of the date of this Complaint, neither RESPONDENT has provided a response to the 233B letter.

12. On July 12, 2024, the Board's inspector prepared an Investigative Report concerning the eight decedents found in the cooler.

PAMALA MIDDLEBROOKS

13. PAMALA MIDDLEBROOKS died on May 9, 2023, and was transferred to RESPONDENTS’ facility the same day.

14. RESPONDENT GRANT initiated the electronic death record on May 9, 2023.

15. A physician signed and certified the death record on May 17, 2023.

16. On May 26, 2023, PAMALA MIDDLEBROOKS's daughter, Brittany Rumery, signed a Cremation Authorization and Order for Disposition form, authorizing RESPONDENTS to arrange for cremation of PAMALA MIDDLEBROOKS.

17. On May 26, 2023, RESPONDENTS and Brittney Rumery completed and signed a form to refer the case to Clark County Social Services (“CCSS”), although RESPONDENT GRANT did not submit the referral at that time.

18. RESPONDENT GRANT signed the death record on December 11, 2023.

19. The Southern Nevada Health District signed the electronic death record and issued burial transit permit on December 11, 2023.

20. On January 10, 2024, CCSS received the above-mentioned referral.

21. CCSS denied the referral on February 5, 2024.

22. GRANT resubmitted a referral on March 19, 2024, though it was withdrawn on April 4, 2024, when RESPONDENTS submitted a private pay notice to CCSS.

23. RESPONDENTS entered a Funeral Arrangement Agreement with PAMALA MIDDLEBROOK's brother and accepted payment on April 4, 2024.

24. RESPONDENTS cremated PAMALA MIDDLEBROOKS on April 4, 2024, 10 months and 26 days after her death.

JOSEPH VOCATURA

25. JOSEPH VOCATURA died on July 7, 2023, and was transferred to RESPONDENTS' facility the same day.

26. RESPONDENT GRANT initiated the electronic death record on July 7, 2023.

27. A doctor certified and signed the electronic death record on July 9, 2023.

28. On July 10, 2023, JOSEPH VOCATURA's daughter, Gia Silveira provided to RESPONDENTS personal information for JOSEPH VOCATURA and signed a cremation authorization.

29. On July 11, 2023, JOSEPH VOCATURA's daughter, Gia Silveira, signed a Clark County Social Services Referral Form.

30. RESPONDENT GRANT signed the electronic death record on July 14, 2023.

31. Southern Nevada Health District registered the death record and issued the burial transit permit on July 14, 2023.

32. CCSS received the first financial assistance referral on September 7, 2023.

33. CCSS denied the referral on October 24, 2023.

34. RESPONDENTS resubmitted the referral on March 20, 2024.

35. CCSS approved the referral on April 2, 2024.

36. JOSEPH VOCTURA was cremated on April 26, 2024, 9 months and 19 days after his death.

DEBY VINCE

37. DEBY VINCE died on August 14, 2023, and was transferred to RESPONDENTS' facility the same day.

38. RESPONDENT GRANT initiated the electronic death record on August 14, 2023.

39. An Advanced Practice Registered Nurse (“APRN”) signed and certified the signed the electronic death record on August 15, 2023.

40. Four months later, on December 15, 2023, RESPONDENT GRANT signed the electronic death record, four months after the APRN certified the death record.

41. The Southern Nevada Health District registered the death record and issued a burial transit permit on January 8, 2024.

42. DEBY VINCE’s sister, Lisa Martin, entered into a contract with RESPONDENT on January 9, 2024.

43. On or about March 1, 2024, CCSS received the first referral from RESPONDENTS for financial assistance. This referral was denied on April 3, 2024.

44. RESPONDENTS submitted to CCSS an Abandoned Body Referral on April 3, 2024.

45. CCSS approved the referral on April 9, 2024.

46. DEBY VINCE was cremated on May 9, 2024, 8 months and 25 days after her death.

CATHERINE LANE-NOVAK

47. CATHERINE LANE-NOVAK died on October 31, 2023, and was transferred to RESPONDENTS’ facility the same day.

48. RESPONDENT GRANT initiated the electronic death record on November 1, 2023.

49. A physician signed and certified the death record on January 22, 2024.

50. RESPONDENT GRANT signed the electronic death record on January 24, 2024.

51. Southern Nevada Health District registered and issued a permit on January 25, 2024.

52. RESPONDENTS sent to CCSS a referral for financial assistance for CATHERINE LANE-NOVAK’s husband, Mark Boehm, on February 2, 2024.

53. CATHERINE LANE-NOVAK’s husband, Mark Boehm, entered into an agreement with RESPONDENTS and signed a Cremation authorization on February 29, 2024.

54. RESPONDENTS cremated CATHERINE LANE-NOVAK on May 24, 2024, 6 months and 25 days after her death.

LONNA LONNING

55. LONNA LONNING died on November 8, 2023, and was transferred to RESPONDENTS' facility the same day.

56. RESPONDENT GRANT initiated the electronic death record on November 9, 2023.

57. On January 3, 2024, LONNA LONNING's significant other, Tamara Reese, entered into an agreement with RESPONDENTS and signed an authorization to cremate.

58. A physician signed and certified the death record on January 20, 2024.

59. RESPONDENT GRANT signed the electronic death record on November 13, 2023, but the personal information was not completed by RESPONDENT GRANT until January 16, 2024.

60. Southern Nevada Health District registered and issued a permit on January 22, 2024.

61. RESPONDENTS filed referral forms with CCSS on December 11, 2023, January 5, 2024. On January 19, 2024, CCSS denied the request for financial assistance for Ms. Reese.

62. On March 1, 2024, RESPONDENTS filed an Abandoned Body Request with CCSS.

63. CCSS authorized the cremation on March 20, 2024.

64. RESPONDENTS cremated LONNA LONNING on April 22, 2024, 5 months and 15 days after her death and 32 days after CCSS authorized cremation.

TERESA JOHN

65. TERESA JOHN died on November 6, 2023, and was initially in the care of Desert Memorial Burial and Cremation.

66. Desert Memorial initiated the electronic death record on November 6, 2023.

67. A physician signed and certified the electronic death record on November 15, 2023.

68. TERESA JOHN was transferred from Desert Memorial to RESPONDENTS' facility on November 17, 2023.

69. RESPONDENTS filed a referral for financial assistance with CCSS on January 4, 2024. CCSS denied the referral on February 2, 2024.

70. RESPONDENT GRANT signed the electronic death record on January 24, 2024.

71. Southern Nevada Health District registered and permitted the case on January 26, 2024.

72. On April 16, 2024, RESPONDENTS filed with CCSS an Abandoned Body Request.

73. On April 17, 2024, CCSS issued an Authorization for Payment of Cremation/Burial.

74. RESPONDENTS cremated TERESA JOHN on May 24, 2024, 6 months and 19 days after her death and 6 months and 8 days after RESPONDENTS had possession of TERESA JOHN's body. The cremation was completed forty-two days after RESONDENTS received authorization to cremate from CCSS.

LAWRENCE PONTERI

75. LAWRENCE PONTERI died on November 23, 2023, and was transferred to RESPONDENTS' facility the same day.

76. On December 1, 2023, LAWRENCE PONTERI's daughter, Elaine Ponteri, entered into a contract with RESPONDENTS for cremation arrangements.

77. On December 11, 2023, RESPONDENTS filed with CCSS referral form for financial assistance for cremation for LAWRENCE PONTERI's daughter.

78. On December 28, 2023, RESPONDENTS filed with CCSS an Abandoned Body Request.

79. On January 16, 2024, CCSS issued an authorization to cremate LAWRENCE PONTERI as an abandoned body.

80. On February 15, 2024, RESPONDENT GRANT initiated the electronic death record, February 15, 2024, was 85 days after RESPONDENTS received the body of LAWRENCE PONTERI at their facility and 30 days after receiving authorization from CCSS to cremate.

81. On February 19, 2024, an APRN signed and certified the death record

82. RESPONDENT GRANT signed the electronic death record on February 16, 2024.

83. The Southern Nevada Health District registered and issued a permit on February 20, 2024.

84. RESPONDENTS cremated LAWRENCE PONTERI on March 4, 2024, 3 months and 8 days after his death and 47 days after receiving authorization to cremate from CCSS.

EDWARD ELLIOTT

85. EDWARD ELLIOTT died on December 13, 2023, and was transferred to RESPONDENTS' facility the same day.

86. RESPONDENT GRANT initiated the electronic death record on December 14, 2023.

87. On December 14, 2023, a physician signed and certified the death record.

88. RESONDENT GRANT signed the electronic death record on December 15, 2023.

89. Southern Nevada Health District registered and issued a permit on December 26, 2023.

90. On January 18, 2024, CCSS authorized the cremation.

91. On January 26, 2024, Southern NHD registered and issued the permit.

92. RESPONDENTS cremated EDWARD ELLIOT on March 5, 2024, 2 months and 22 days after his death and 47 days after cremation was authorized.

93. On July 10, 2024, the Board's inspector, Dr. Wayne Fazzino, ("Board Inspector") conducted an inspection of McDERMOTT'S located at 2121 Western Avenue in Las Vegas.

94. The purpose of the visit was to inspect the crematory and the coolers to determine if decedents were being properly stored. The Board recently documented that eight decedents were in the care of McDermott's for an extended period. This was a follow up inspection to make sure decedents were being housed and buried/cremated in a timely manner.

95. Upon the Board Inspector's arrival, both crematory entrances were wide open. The Board Inspector walked around the crematory for several minutes until Jorge Medrano Ceja ("CEJA"), a funeral arranger and employee of McDERMOTT'S, walked into the crematory. One retort was open with cremated remains present. Proper paperwork was posted to identify the decedent.

96. The Board Inspector inspected the facility's coolers. Three coolers contained numerous bodies that were leaking blood and bodily fluids.

- a. The body of Dorothea Nordstrom (Case 10366) was leaking a yellow fluid that stained the white sheet in which she was wrapped. Ms. Nordstrom died on November 1, 2023 (252 days prior to this inspection).
- b. The body of Mabel Acree was leaking blood and fluid through her sheet. It was difficult to decipher her name and case number because of the leakage. Ms. Acree died March 17, 2024 (115 days prior to this inspection).
- c. The body of a third individual ("hereinafter referred to as "Unknown Decedent 1") was housed on the bottom shelf against the wall. The Board Inspector was not able to identify the individual and did not want to touch the sheet because of the amount of blood. There was blood on the side wall also.

- d. The body of Lesly Lemus Arriaza was housed in an open box on rollers. There was no lid in the cooler or around the body to cover her.
- e. The body of Tammy Fawcett was situated on a table. Bodily fluids were evident on the sheet. Ms. Fawcett died June 26, 2024 (14 days prior to this inspection).
- f. The body of Patricia Davis was housed on a bottom shelf. There was blood and bodily fluids on her sheet as well as on the sheet above her. She died July 9, 2024 (the day before this inspection).
- g. The body of Adrian Clark was housed on a shelf. There was a large amount of bodily fluid and blood both on the sheet and on the shelf. The fluid was a quarter inch thick on the shelf. Adrian Clark died April 26, 2024 (75 days prior to this inspection).
- h. The body of Stephen McGuire was housed on a shelf. There was blood and bodily fluid on the sheet. He died on May 27, 2024, of Covid 19 (44 days prior to the inspection).
- i. The body of Randy Chaney was housed on a table. There was a large amount of bodily fluid and blood soaking through the sheet. He died April 30, 2024 (71 days prior to this inspection).
- j. Two other bodies (hereinafter referred to as “Unknown Decedent 2” and “Unknown Decedent 3”) were in the cooler that were leaking blood and what appears to be urine. No names were visible.
- k. Inside of Cooler 4 was the remains of a baby that was on the top shelf, identified as Baby Buzuneh (Case 11265). Baby Buzuneh died June 26, 2024 (14 days prior to this inspection).

97. At the conclusion of the inspection, the Board Inspector noticed that staff placed two curtains by the main crematory entrance, apparently to block the public from looking in. The curtains were not present when the Board Inspector arrived for the inspection.

98. The Board Inspector discussed the findings with CEJA and RESPONDENT GRANT and was told that they would re-wrap those in soiled sheets.

1 99. On August 5, 2024, based on the findings of this inspection, Board Executive Director
2 Stephanie McGee filed an Informal Administrative Complaint against RESPONDENTS.

3 100. On August 5, 2024, Board Executive Director Stephanie McGee sent a Notice of
4 Summary of Informal Complaint (“233B Letter”) to RESPONDENTS.

5 101. As of the date of this Complaint, neither RESPONDENT has provided a response to the
6 233B letter.

7 102. On August 19, 2024, the Board Inspector returned to McDERMOTT’S facility to conduct
8 an unannounced annual inspection.

9 103. The Board inspector arrived at 8:00 am and upon arrival the facility was closed.

10 104. At 8:25 AM, McDermott's crematory operator, Rolando Tiscareno (“TISCARENO”),
11 arrived and opened the crematory doors. Mr. Tiscareno assisted the Board Inspector as he inspected each
12 of the four coolers where he documented the decedents by name and date of death. Again, the Board
13 inspector found numerous bodies wrapped in soiled sheets.

14 a. The body of Dartha Nordstrom was wrapped in soiled sheets. Dartha Nordstrom died
15 on November 1, 2023 (292 days prior to this inspection). Dartha Nordstrom was one
16 of the decedents that was first noticed on the July 10th inspection.

17 b. The body of Mabel Acree was wrapped in soiled sheets. Mabel Acree died on March
18 17, 2024 (155 days prior to this inspection). Mabel Acree was one of the decedents
19 that was first noticed on the July 10th inspection.

20 c. The body of Dana Hamel was wrapped in soiled sheets. Dana Hamel died on July 14,
21 2024 (36 days prior to this inspection).

22 d. The body of John Wilmot was wrapped in soiled sheets. John Wilmot died on August
23 3, 2024 (16 days prior to this inspection).

24 e. The body of Steve Taylor was wrapped in soiled sheets. Steve Taylor died on August
25 4, 2024 (15 days prior to this inspection).

26 f. The body of Adrian Clark was wrapped in soiled sheets. Adrian Clark died on April
27 26, 2024 (115 days prior to this inspection). Adrian Clark was one of the decedents
28 that was first noticed on the July 10th inspection.

g. The body of David McCann was wrapped in soiled sheets. David McCann died on May 11, 2024 (100 days prior to this inspection).

h. The body of Baby Buzuneh was wrapped in soiled sheets. Baby Buzuneh died on June 26, 2024 (54 days prior to this inspection). Baby Buzuneh was one of the decedents that was first noticed on the July 10th inspection.

i. The body of Kelly Covington was wrapped in soiled sheets. Kelly Covington died on June 27, 2024 (53 days prior to this inspection).

105. Dartha Nordstrom, Mabel Acree, Clark Adrian, and Baby Buzuneh were documented in the July 10, 2024, inspection. Their sheets had not been changed, and they were still in the same condition as noted in the July 10, 2024, inspection, one month and 9 days prior to this inspection. This is despite being told that the bodies would be re-wrapped. (See paragraph 11 above).

106. The Board Inspector was told by RESPONDENT GRANT that he does not have a funeral arranger to take over the duties performed by former funeral arranger, CEJA. Currently, TISCARENO is the only person working in the crematory.

107. As to decedent Dana Hamel (mentioned in paragraph 7(c) above), Hamel died on July 14, 2024, at Mountain View Hospital. The family released decedent Hamel to Palm Mortuary West Cheyenne, Las Vegas, Nevada.

108. On July 19, 2024, Decedent Hamel was released by Palm's Care Center to McDERMOTT'S. It was stated on Palm's Decedent Identification & Release Form, under condition of decedent, casket, shipping container etc., that decedent was "plastic good."

109. As explained by Palm's Downtown Care Center to Board Inspector, "plastic good" means the body was wrapped and in good condition.

110. Pictures taken during the annual inspection (August 19, 2024) reflect that decedent was leaking body fluids on the floor, there was blood and body fluids on decedent, his sheet, and the rack he was situated on.

111. At the time of the inspection, decedent Hamel had been in McDERMOTT'S care for four weeks (36 days).

1 112. On January 15, 2025, the Board Inspector made a request to Clark County Social Services
2 surrounding the nine decedents in the care of McDERMOTT'S noted above concerning the August 19th
3 inspection. The Board Inspector was provided a chart to reflect their interaction with McDERMOTT'S
4 and McDERMOTT'S efforts to cremate/bury decedents in a timely manner.

5 113. No referrals were made by McDERMOTT'S to Clark County Social Services for
6 decedents, Hamel, Wilmot, Taylor, McCann, Baby Buzuneh, and Covington.

7 114. Decedent Nordstrom was referred January 5, 2024. (approximately 2 months after her
8 death).

9 115. In the matter of decedents Acree and Clark, McDERMOTT'S referred them to social
10 services within thirty-days of their deaths.

11 116. Numerous requests were made by the Board Inspector of RESPONDENT GRANT to
12 provide intake and cremation logs for 2023 and 2024.

13 117. These requests were made to correct missing death and birth dates, accurate spelling of
14 decedent names, extremely poor handwritten case numbers and decedent names on sheets and tags, and
15 missing documents that should have been in files. In some cases, blood and soiled sheets covered names
16 and case numbers.

17 118. Many email requests were made of RESPONDENT GRANT to identify decedents in his
18 care because of these problems.

19 119. RESPONDENT GRANT has not been able to provide one crematory binder that contains
20 log intake log sheets for January 2023 to July 2023. Mr. Grant informed the Board Inspector that he
21 checked everywhere and consulted with two former crematory-operators to locate the missing binder.

22 CONCLUSIONS OF LAW

23 The Board has considered all relevant statutes and regulations, and specifically:

24 120. NRS 642.5175 which sets out the grounds for which the Board may take certain
25 disciplinary action, and states in pertinent part:

26 **NRS 642.5175 Grounds.** The following acts are grounds for which the
27 Board may take disciplinary action against any person who holds a license,
28 permit or certificate issued by the Board pursuant to this chapter or [chapter](#)

1 [451](#) or [452](#) of NRS, or may refuse to issue such a license, permit or
2 certificate to an applicant therefor:

3 ...

4 **2. Unprofessional conduct.**

5 121. NRS 642.5174 which defines “unprofessional conduct” as it relates to NRS 642.5175, and
6 states in pertinent part:

7 **NRS 642.5174 “Unprofessional conduct” defined.** For the purposes
8 of [NRS 642.5175](#), unprofessional conduct includes:

9 1. Misrepresentation or fraud in the operation of a funeral
10 establishment, direct cremation facility, cemetery or crematory, or the
11 practice of a funeral director or funeral arranger.

12 ...

13 11. Violation of any provision of this chapter, any regulation adopted
14 pursuant thereto or any order of the Board.

15 12. Violation of any state law or municipal or county ordinance or
16 regulation affecting the handling, custody, care or transportation of dead
17 human bodies, including, without limitation, [chapters 440](#), [451](#) and [452](#) of
18 NRS.

19 ...

20 15. Taking undue advantage of the patrons of a funeral establishment or
21 direct cremation facility, or being guilty of fraud or misrepresentation in the
22 sale of merchandise to those patrons

23 18. Unethical practices contrary to the public interest as determined
24 by the Board.

25 122. NRS 451.020 which sets forth that a decedent must be buried or cremated within a
26 reasonable time, and states in pertinent part:

27 **NRS 451.020 Burial or cremation within reasonable time after
28 death; transportation and disposal of residue of cremated body.**

1 1. Except in cases of dissection provided for in NRS 451.010, and
2 where a dead body shall rightfully be carried through or removed from the
3 State for the purpose of burial elsewhere, **every dead body of a human
4 being** lying within this state, and the remains of any dissected body after

dissection, **shall be decently buried or cremated within a reasonable time after death.**

...

123. NRS 440.490 which sets the requirement for a funeral director to present the completed certificate of death to the local registrar within 72 hours after the occurrence or discovery of the death, and states:

NRS 440.490 Presentation of completed certificate of death to local registrar. The funeral director or person acting as undertaker shall present the completed certificate of death to the local registrar within 72 hours after the occurrence or discovery of the death. If a case is referred to the coroner, he or she shall present a completed certificate to the local registrar upon disposition of the investigation.

124. NAC 440.162 which sets out that a funeral director must initiate a death certificate within 24 hours of receiving a body.

NAC 440.162 Time for initiation of certificate of death or fetal death.
A person completing a certificate of death or fetal death must initiate the certificate:

...

2. If initiated by a funeral director, not later than 24 hours after the funeral director receives the corpse.

125. NRS 642.345 which sets out that a funeral director is responsible for the proper management of each funeral establishment, and states in pertinent part:

NRS 642.345 Funeral directors: Management of funeral establishment or direct cremation facility prohibited without approval of Board; responsibilities.

...

3. A funeral director is responsible for the proper management of each funeral establishment or direct cremation facility of which the funeral director is the manager.

126. NRS 642.465 proves that a funeral establishment must be maintained in a sanitary and professional manner, and states in pertinent part:

NRS 642.465 Contents and display of permit; operation and advertisement of funeral establishment or direct cremation facility by person named on permit; maintenance of facility; no prohibition on embalming at central location.

...

3. Each funeral establishment and direct cremation facility which has been issued a permit by the Board pursuant to this chapter or [chapter](#)

451 or 452 of NRS shall maintain its facilities in a sanitary and professional manner.

127. NRS 451.675 discusses the requirements of holding remains awaiting cremation. NRS 451.675 Holding of remains awaiting cremation.

1. If the operator of a crematory cannot cremate human remains immediately after receiving them, the operator shall place them in a holding facility within or adjacent to the crematory which:

- (a) Preserves the dignity of the remains;
- (b) Protects for the health and safety of employees of the operator; and
- (c) Is secure from access by anyone other than those employees, except a laborer in the ordinary course of his or her work.

2. If human remains are not embalmed, they may not be held longer than 24 hours unless the holding facility is refrigerated.

3. An operator need not accept for holding a container from which there is any evidence of leakage of bodily fluids.

128. NAC 642.158 discusses the proper care of human remains.

NAC 642.158 Proper care and storage of human remains. (NRS 642.063)

1. Each holder of a license, permit or certificate issued by the Board pursuant to chapter 451, 452 or 642 of NRS shall ensure that human remains are treated with dignity and respect at all times.

2. Human remains must be clothed or completely covered while the human remains are being refrigerated and after the human remains have been embalmed.

3. Human remains, or human remains which have been placed in a minimal container, body bag or casket, must not be placed or stored directly on the floor of any room used to store human remains. For the purposes of this subsection, "floor of any room" includes the floor of a room which is part of a refrigeration unit.

4. Human remains must be stored and transported face up at all times.

5. Human remains, or human remains which have been placed in a minimal container, body bag or casket, must not be placed on other human remains, or human remains which have been placed in a minimal container, body bag or casket, for the purpose of storage or transportation.

6. The premises of any location where human remains are stored must be maintained in a sanitary and professional manner.

129. NAC 451.200 requires a funeral establishment to maintain records for at least 7 years, and states in pertinent part:

NAC 451.200 Maintenance of records. (NRS 451.640, 452.026, 642.063)

1. The records required to be kept pursuant to NRS 451.665 by the operator of a crematory, funeral establishment or direct cremation facility must be maintained for at least 7 years.

2. The maintenance of such records in a digital format satisfies the requirements of subsection 1.

130. NAC 642.180 which sets out the requirement for a licensee to respond to the receipt of a 233B letter within 15 days and to respond with an Answer to a Formal Complaint within 15 days, and states in pertinent part:

NAC 642.180 Procedure for disciplinary action.

...

4. **Upon the receipt of a summary of an informal complaint that has been filed against him or her, a licensee shall submit to the Board a written response to the informal complaint within 15 days after the date on which the informal complaint was served.** A response to an informal complaint must respond to the allegations made in the informal complaint and be accompanied by all documentation that would be useful to the staff and legal counsel in their review of the allegations made in the informal complaint and the responses made by the licensee to those allegations. Failure by a licensee to cooperate with the Board during an investigation of an informal complaint, including, without limitation, **failing to respond timely to the Board regarding a summary of the informal complaint sent to the licensee by the staff pursuant to this subsection, is a ground for disciplinary action by the Board against the licensee.**

5. If a licensee fails to respond as required pursuant to subsection 4, he or she shall be deemed to have admitted the allegations in the informal complaint. Based on these admissions, the Board may impose appropriate discipline on the licensee at the hearing on the informal complaint.

...

12. A respondent who receives a notice of hearing and a formal complaint shall file his or her answer to the notice of hearing and the formal complaint not later than 15 days after the date on which the respondent received the notice of hearing and the formal complaint. An answer to a notice of hearing and a formal complaint filed by a respondent must include a response to each allegation and statement made in the notice of hearing and the formal complaint by either admitting to or denying the allegation or statement. If the licensee fails to file an answer as required pursuant to this subsection, the licensee shall be deemed to have admitted each allegation and statement contained in the notice of hearing and the formal complaint. Based on these admissions, the Board may enter a finding and impose appropriate discipline on the licensee in the same manner as if the allegations had been proven by substantial evidence at a hearing of the Board held on the formal complaint.

131. NRS 642.5176 which sets out the authorized discipline as such:

NRS 642.5176 Authorized disciplinary action; private reprimands prohibited; orders imposing discipline deemed public records.

1. If the Board determines that a person who holds a license, permit or certificate issued by the Board pursuant to this chapter or [chapter 451](#) or [452](#) of NRS has committed any of the acts set forth in [NRS 642.5175](#), the Board may:

- (a) Refuse to renew the license, permit or certificate;
- (b) Revoke the license, permit or certificate;
- (c) Suspend the license, permit or certificate for a definite period or until further order of the Board;
- (d) Impose a fine of not more than \$5,000 for each act that constitutes a ground for disciplinary action;
- (e) Place the person on probation for a definite period subject to any reasonable conditions imposed by the Board;
- (f) Administer a public reprimand; or
- (g) Impose any combination of disciplinary actions set forth in paragraphs (a) to (f), inclusive.

2. The Board shall not administer a private reprimand.

3. An order that imposes discipline and the findings of fact and conclusions of law supporting that order are public records

The Board, in considering the relevant statutes and regulations and as evidenced by the facts described above, finds and concludes that RESPONDENTS committed the following violations of law:

132. In the matter of PAMALA MIDDLEBROOKS, GRANT violated NRS 440.490 when he failed to present the completed certificate of death to the local registrar within 72 hours after the occurrence or discovery of the death.

133. In the matter of PAMALA MIDDLEBROOKS, GRANT violated NRS 451.020 when he failed to bury or cremate the decedent within a reasonable time after death.

1 134. In the matter of PAMALA MIDDLEBROOKS, GRANT violated NRS 642.5174(18),
2 when he, as described by the above related facts to include the various delays throughout the entire
3 process from death to cremation, engaged in unethical practices contrary to the public interest.

4 135. In the matter of JOSEPH VOCATURA, GRANT violated NRS 440.490 when he failed
5 to present the completed certificate of death to the local registrar within 72 hours after the occurrence or
6 discovery of the death.

7 136. In the matter of JOSEPH VOCATURA, GRANT violated NRS 451.020 when he failed
8 to bury or cremate the decedent within a reasonable time after death.

9 137. In the matter of JOSEPH VOCATURA, GRANT violated NRS 642.5174(18), when he,
10 as described by the above related facts to include the various delays throughout the entire process from
11 death to cremation, engaged in unethical practices contrary to the public interest.

12 138. In the matter of DEBY VINCE, GRANT violated NRS 440.490 when he failed to present
13 the completed certificate of death to the local registrar within 72 hours after the occurrence or discovery
14 of the death.

15 139. In the matter of DEBY VINCE, GRANT violated NRS 451.020 when he failed to bury
16 or cremate the decedent within a reasonable time after death.

17 140. In the matter of DEBY VINCE, GRANT violated NRS 642.5174(18), when he, as
18 described by the above related facts to include the various delays throughout the entire process from
19 death to cremation, engaged in unethical practices contrary to the public interest.

20 141. In the matter of CATHERINE LANE-NOVAK, GRANT violated NRS 440.490 when he
21 failed to present the completed certificate of death to the local registrar within 72 hours after the
22 occurrence or discovery of the death.

23 142. In the matter of CATHERINE LANE-NOVAK, GRANT violated NRS 451.020 when he
24 failed to bury or cremate the decedent within a reasonable time after death.

25 143. In the matter of CATHERINE LANE-NOVAK, GRANT violated NRS 642.5174(18),
26 when he, as described by the above related facts to include the various delays throughout the entire
27 process from death to cremation, engaged in unethical practices contrary to the public interest.
28

1 144. In the matter of LONNA LONNING, GRANT violated NRS 440.490 when he failed to
2 present the completed certificate of death to the local registrar within 72 hours after the occurrence or
3 discovery of the death.

4 145. In the matter of LONNA LONNING, GRANT violated NRS 451.020 when he failed to
5 bury or cremate the decedent within a reasonable time after death.

6 146. In the matter of LONNA LONNING, RESPONDENTS violated NRS 642.5174(18),
7 when they, as described by the above related facts to include the various delays throughout the entire
8 process from death to cremation, engaged in unethical practices contrary to the public interest.

9 147. In the matter of TERESA JOHN, RESPONDENT GRANT violated NRS 440.490 when
10 he failed to present the completed certificate of death to the local registrar within 72 hours after the
11 occurrence or discovery of the death.

12 148. In the matter of TERESA JOHN, RESPONDENTS violated NRS 451.020 when they
13 failed to bury or cremate the decedent within a reasonable time after death.

14 149. In the matter of TERESA JOHN, RESPONDENTS violated NRS 642.5174(18), when
15 they, as described by the above related facts to include the various delays throughout the entire process
16 from death to cremation, engaged in unethical practices contrary to the public interest.

17 150. In the matter of LAWRENCE PONTERI, RESPONDENT GRANT violated NRS
18 440.490 when he failed to present the completed certificate of death to the local registrar within 72 hours
19 after the occurrence or discovery of the death.

20 151. In the matter of LAWRENCE PONTERI, RESPONDENT GRANT violated NAC
21 440.162 when he failed to initiate the death record within 24 hours of receiving the body.

22 152. In the matter of LAWRENCE PONTERI, RESPONDENTS VIOLATED NRS 451.020
23 when they failed to bury or cremate the decedent within a reasonable time after death.

24 153. In the matter of LAWRENCE PONTERI, RESPONDENTS violated NRS 642.5174(18),
25 when they, as described by the above related facts to include the various delays throughout the entire
26 process from death to cremation, engaged in unethical practices contrary to the public interest.

1 154. In the matter of EDWARD ELLIOT, RESPONDENT GRANT violated NRS 440.490
2 when he failed to present the completed certificate of death to the local registrar within 72 hours after the
3 occurrence or discovery of the death.

4 155. In the matter of EDWARD ELLIOT, RESPONDENTS VIOLATED NRS 451.020 when
5 they failed to bury or cremate the decedent within a reasonable time after death.

6 156. In the matter of EDWARD ELLIOT, RESPONDENTS violated NRS 642.5174(18), when
7 they, as described by the above related facts to include the various delays throughout the entire process
8 from death to cremation, engaged in unethical practices contrary to the public interest.

9 157. In the matter of the 233B letter that was sent on March 18, 2024, RESPONDENTS
10 violated NRS 642.180(4) when they failed to submit to the Board a written response within 15 days.

11 158. In the matter of Dorothea Nordstrom, GRANT violated NRS 451.020 when he failed to
12 bury or cremate the decedent within a reasonable time after death.

13 159. In the matter of Dorothea Nordstrom, GRANT violated NRS 451.675 when he placed her
14 body in a facility that failed to preserve the dignity of the remains and protect for the health and safety of
15 employees of the operator.

16 160. In the matter of Dorothea Nordstrom, RESPONDENTS violated NAC 642.158 when they
17 failed to ensure that her remains were treated with dignity and respect at all times.

18 161. In the matter of Dorothea Nordstrom, GRANT violated NRS 642.5174(18), when he, as
19 described by the above related facts, engaged in unethical practices contrary to the public interest.

20 162. In the matter of Mabel Acree, GRANT violated NRS 451.020 when he failed to bury or
21 cremate the decedent within a reasonable time after death.

22 163. In the matter of Mabel Acree, GRANT violated NRS 451.675 when he placed the
23 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
24 and safety of employees of the operator.

25 164. In the matter of Mabel Acree, RESPONDENTS violated NAC 642.158 when they failed
26 to ensure that her remains were treated with dignity and respect at all times.

27 165. In the matter of Mabel Acree, GRANT violated NRS 642.5174(18), when he, as described
28 by the above related facts, engaged in unethical practices contrary to the public interest.

1 166. In the matter of Unknown Decedent 1, GRANT violated NRS 451.675 when he placed
2 the decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
3 and safety of employees of the operator.

4 167. In the matter of Unknown Decedent 1, RESPONDENTS violated NAC 642.158 when
5 they failed to ensure that her remains were treated with dignity and respect at all times.

6 168. In the matter of Unknown Decedent 1, GRANT violated NRS 642.5174(18), when he, as
7 described by the above related facts, engaged in unethical practices contrary to the public interest.

8 169. In the matter of Lesly Lemus Arriaza, GRANT violated NRS 451.675 when he placed the
9 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
10 and safety of employees of the operator.

11 170. In the matter of Lesly Lemus Arriaza, RESPONDENTS violated NAC 642.158 when they
12 failed to ensure that her remains were treated with dignity and respect at all times.

13 171. In the matter of Lesly Lemus Arriaza, GRANT violated NRS 642.5174(18), when he, as
14 described by the above related facts, engaged in unethical practices contrary to the public interest.

15 172. In the matter of Tammy Fawcett, GRANT violated NRS 451.020 when he failed to bury
16 or cremate the decedent within a reasonable time after death.

17 173. In the matter of Tammy Fawcett, GRANT violated NRS 451.675 when he placed the
18 decedent's body in a facility that failed to preserve the dignity of the remains and protect for the health
19 and safety of employees of the operator.

20 174. In the matter of Tammy Fawcett, RESPONDENTS violated NAC 642.158 when they
21 failed to ensure that her remains were treated with dignity and respect at all times.

22 175. In the matter of Tammy Fawcett, GRANT violated NRS 642.5174(18), when he, as
23 described by the above related facts, engaged in unethical practices contrary to the public interest.

24 176. In the matter of Patricia Davis, GRANT violated NRS 451.675 when he placed the
25 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
26 and safety of employees of the operator.

27 177. In the matter of Patricia Davis, RESPONDENTS violated NAC 642.158 when they failed
28 to ensure that her remains were treated with dignity and respect at all times.

1 178. In the matter of Patricia Davis, GRANT violated NRS 642.5174(18), when he, as
2 described by the above related facts, engaged in unethical practices contrary to the public interest.

3 179. In the matter of Adrian Clark, GRANT violated NRS 451.020 when he failed to bury or
4 cremate the decedent within a reasonable time after death.

5 180. In the matter of Adrian Clark, GRANT violated NRS 451.675 when he placed the
6 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
7 and safety of employees of the operator.

8 181. In the matter of Adrian Clark, RESPONDENTS violated NAC 642.158 when they failed
9 to ensure that her remains were treated with dignity and respect at all times.

10 182. In the matter of Adrian Clark, GRANT violated NRS 642.5174(18), when he, as described
11 by the above related facts, engaged in unethical practices contrary to the public interest.

12 183. In the matter of Stephen McGuire, GRANT violated NRS 451.020 when he failed to bury
13 or cremate the decedent within a reasonable time after death.

14 184. In the matter of Stephen McGuire, GRANT violated NRS 451.675 when he placed the
15 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
16 and safety of employees of the operator.

17 185. In the matter of Stephen McGuire, RESPONDENTS violated NAC 642.158 when they
18 failed to ensure that her remains were treated with dignity and respect at all times.

19 186. In the matter of Stephen McGuire, GRANT violated NRS 642.5174(18), when he, as
20 described by the above related facts, engaged in unethical practices contrary to the public interest.

21 187. In the matter of Randy Chaney, GRANT violated NRS 451.020 when he failed to bury or
22 cremate the decedent within a reasonable time after death.

23 188. In the matter of Randy Chaney, GRANT violated NRS 451.675 when he placed the
24 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
25 and safety of employees of the operator.

26 189. In the matter of Randy Chaney, RESPONDENTS violated NAC 642.158 when they failed
27 to ensure that her remains were treated with dignity and respect at all times.

28 190. In the matter of Randy Chaney, GRANT violated NRS 642.5174(18), when he, as

described by the above related facts, engaged in unethical practices contrary to the public interest

191. In the matter of Unknown Decedent 2, GRANT violated NRS 451.675 when he placed the decedents body in a facility that failed to preserve the dignity of the remains and protect for the health and safety of employees of the operator.

192. In the matter of Unknown Decedent 2, RESPONDENTS violated NAC 642.158 when they failed to ensure that her remains were treated with dignity and respect at all times.

193. In the matter of Unknown Decedent 2, GRANT violated NRS 642.5174(18), when he, as described by the above related facts, engaged in unethical practices contrary to the public interest.

194. In the matter of Unknown Decedent 3, GRANT violated NRS 451.675 when he placed the decedents body in a facility that failed to preserve the dignity of the remains and protect for the health and safety of employees of the operator.

195. In the matter of Unknown Decedent 3, RESPONDENTS violated NAC 642.158 when they failed to ensure that her remains were treated with dignity and respect at all times.

196. In the matter of Unknown Decedent 3, GRANT violated NRS 642.5174(18), when he, as described by the above related facts, engaged in unethical practices contrary to the public interest.

197. In the matter of Baby Buzuneh, GRANT violated NRS 451.020 when he failed to bury or cremate the decedent within a reasonable time after death.

198. In the matter of Baby Buzuneh, GRANT violated NRS 451.675 when he placed the decedents body in a facility that failed to preserve the dignity of the remains and protect for the health and safety of employees of the operator.

199. In the matter of Baby Buzuneh, RESPONDENTS violated NAC 642.158 when they failed to ensure that her remains were treated with dignity and respect at all times.

200. In the matter of Baby Buzuneh, GRANT violated NRS 642.5174(18), when he, as described by the above related facts, engaged in unethical practices contrary to the public interest.

201. In the matter of Dana Hamel, GRANT violated NRS 451.020 when he failed to bury or cremate the decedent within a reasonable time after death.

202. In the matter of Dana Hamel, GRANT violated NRS 451.675 when he placed the decedents body in a facility that failed to preserve the dignity of the remains and protect for the health

1 and safety of employees of the operator.

2 203. In the matter of Dana Hamel, RESPONDENTS violated NAC 642.158 when they failed
3 to ensure that her remains were treated with dignity and respect at all times.

4 204. In the matter of Dana Hamel, GRANT violated NRS 642.5174(18), when he, as described
5 by the above related facts, engaged in unethical practices contrary to the public interest.

6 205. In the matter of John Wilmot, GRANT violated NRS 451.020 when he failed to bury or
7 cremate the decedent within a reasonable time after death.

8 206. In the matter of John Wilmot, GRANT violated NRS 451.675 when he placed the
9 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
10 and safety of employees of the operator.

11 207. In the matter of John Wilmot, RESPONDENTS violated NAC 642.158 when they failed
12 to ensure that her remains were treated with dignity and respect at all times.

13 208. In the matter of John Wilmot, GRANT violated NRS 642.5174(18), when he, as described
14 by the above related facts, engaged in unethical practices contrary to the public interest.

15 209. In the matter of Steve Taylor, GRANT violated NRS 451.020 when he failed to bury or
16 cremate the decedent within a reasonable time after death.

17 210. In the matter of Steve Taylor, GRANT violated NRS 451.675 when he placed the
18 decedents body in a facility that failed to preserve the dignity of the remains and protect for the health
19 and safety of employees of the operator.

20 211. In the matter of Steve Taylor, RESPONDENTS violated NAC 642.158 when they failed
21 to ensure that her remains were treated with dignity and respect at all times.

22 212. In the matter of Steve Taylor, GRANT violated NRS 642.5174(18), when he, as described
23 by the above related facts, engaged in unethical practices contrary to the public interest.

24 213. In the matter of David McCann, GRANT violated NRS 451.020 when he failed to bury
25 or cremate the decedent within a reasonable time after death.

26 214. In the matter of David McCann, GRANT violated NRS 451.675 when he placed the
27 decedents body in a facility that failed to preserve the dignity of the remains and protect for
28 the health and safety of employees of the operator.

215. In the matter of David McCann, RESPONDENTS violated NAC 642.158 when they failed to ensure that her remains were treated with dignity and respect at all times.

216. In the matter of David McCann, GRANT violated NRS 642.5174(18), when he, as described by the above related facts, engaged in unethical practices contrary to the public interest.

217. In the matter of Kelly Covington, GRANT violated NRS 451.020 when he failed to bury or cremate the decedent within a reasonable time after death.

218. In the matter of Kelly Covington, GRANT violated NRS 451.675 when he placed the decedents body in a facility that failed to preserve the dignity of the remains and protect for the health and safety of employees of the operator.

219. In the matter of Kelly Covington, RESPONDENTS violated NAC 642.158 when they failed to ensure that her remains were treated with dignity and respect at all times.

220. In the matter of Kelly Covington, GRANT violated NRS 642.5174(18), when he, as described by the above related facts, engaged in unethical practices contrary to the public interest.

221. In the matter of maintaining the facility, RESPONDENTS violated NRS 642.465 when they failed to maintain the funeral establishment in a sanitary and professional manner.

222. In the matter of the 233B letter that was sent on August 5, 2024, RESPONDENTS violated NRS 642.180(4) when they failed to submit to the Board a written response within 15 days.

223. In the matter of not maintaining records, RESPONDENTS violated NRS 451.665 and NAC 451.200 when they were unable to locate and failed to produce a crematory intake log book.

224. In each of the matters of at issue in these joined complaints, RESPONDENT GRANT failed to properly manage the funeral establishment for which he is the manager.

ORDER

IT IS HEREBY ORDERED, by unanimous decision of the board as follows:

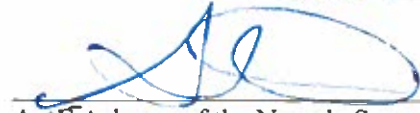
225. RESPONDENT GRANT's Funeral Director license is hereby REVOKED. Respondent GRANT may not reapply for a Funeral Director license until 5 years have passed from the date of the entry of this ORDER. Additionally, even if granted a new Funeral Director license, RESPONDENT GRANT may not be the Managing Funeral Director of any Establishment until 10 years have passed from the date the entry of this ORDER.

CERTIFICATE OF SERVICE

I hereby certify that on the 18 day of August, 2025, I served a true and correct copy of the foregoing FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER by depositing a copy of the same in the United States mail, properly addressed, postage prepaid, CERTIFIED and REGULAR MAIL addressed as follows:

McDermott's Funeral and Crematory Service
Christopher M. Grant
2121 Western Avenue, Suite 3A
Las Vegas, NV, 89102

Certified Mail No. 9589 0710 5270 00429919 Y3



An Employee of the Nevada State Board of Funeral & Cemetery Services

EXHIBIT 1

Office of the Attorney General

Listing Report with Task Codes

Date	Prof	Matter ID/Client Sort Matter Description Narrative	Component	Task Code	Units	Price	Value
Matter ID: 50913-160							
08/01/2024	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Review email and case file	T	LIT PROS	0.25	157.04	39.26
04/03/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Review Investigative Report	T	LIT PROS	3.00	157.04	471.12
04/04/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Prepare Complaint	T	LIT PROS	4.00	157.04	628.16
04/10/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Prepare Complaint	T	LIT PROS	4.75	157.04	745.94
04/11/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Prepare complaint	T	LIT PROS	6.00	157.04	942.24
04/15/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Revise Complaint	T	LIT PROS	0.50	157.04	78.52
06/16/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Prepare exhibits	T	LIT PROS	2.00	157.04	314.08
08/03/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Prepare for hearing	T	LIT PROS	2.00	157.04	314.08
08/05/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Prepare for Hearing	T	LIT PROS	1.00	157.04	157.04

Office of the Attorney General

Listing Report with Task Codes

Date	Prof	Matter ID/Client Sort Matter Description Narrative	Component	Task Code	Units	Price	Value
08/07/2025	MPF	50913-160/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-06 Hearing on Disciplinary Complaint	T	HRG/APP	2.00	157.04	314.08
				Matter ID: 50913-160	25.50		4,004.52
				Grand Total:	25.50		\$4,004.52

Office of the Attorney General

Listing Report with Task Codes

Date	Prof	Matter ID/Client Sort Matter Description Narrative	Component	Task Code	Units	Price	Value
Matter ID: 50913-162							
08/06/2024	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Review matter	T	LIT PROS	0.50	157.04	78.52
06/03/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Draft Complaint	T	LIT PROS	2.00	157.04	314.08
06/04/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Draft Complaint	T	LIT PROS	7.00	157.04	1,099.28
06/05/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Prepare Complaint	T	LIT PROS	2.00	157.04	314.08
06/16/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Prepare exhibits	T	LIT PROS	2.00	157.04	314.08
06/17/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Prepare exhibits	T	LIT PROS	2.00	157.04	314.08
07/03/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Review of letters sent from Chris Grant	T	LIT PROS	1.00	157.04	157.04
08/03/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Prepare for Hearing	T	LIT PROS	2.00	157.04	314.08
08/05/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Prepare for Hearing	T	LIT PROS	1.00	157.04	157.04

Office of the Attorney General

Listing Report with Task Codes

Date	Prof	Matter ID/Client Sort Matter Description Narrative	Component	Task Code	Units	Price	Value
08/07/2025	MPF	50913-162/ Board of Funeral & Cemetery Services (20111) McDermott's Funeral and Cremation Service- Admin FB24-16 Hearing on Disciplinary Complaint	T	HRG/APP	2.00	157.04	314.08
				Matter ID: 50913-162	21.50		3,376.36
				Grand Total:	21.50		\$3,376.36