

REGISTER OF DEEDS
SAUNDERS CO. NEBR.

2013 FEB 12 AM 7:33

BOOK 433 PAGE 702
OF GEN INST# 176

Paul

After recording return to:
Bromm, Lindahl, Freeman-Caddy & Lausterer
P O Box 277
Wahoo, NE 68066

PLEASE RECORD AND INDEX AS TO THE FOLLOWING DESCRIBED REAL ESTATE, TO
WIT:

The South Half of the ^{NORTH}~~South~~west Quarter of Section 14, Township 16, Range 5 East
of the 6th P.M., Saunders County, Nebraska,

AND

The Southwest Quarter of Section 14, Township 16 North, Range 5, East of the 6th
P.M., Saunders County, Nebraska.

48305789

STATE OF NEBRASKA

WHEN THIS COPY CARRIES THE RAISED SEAL OF THE NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES, IT CERTIFIES THE BELOW TO BE A TRUE COPY OF THE ORIGINAL RECORD ON FILE WITH THE NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES, VITAL RECORDS OFFICE, WHICH IS THE LEGAL DEPOSITORY FOR VITAL RECORDS.

DATE OF ISSUANCE

NOV 30 2011

LINCOLN, NEBRASKA

STANLEY S. COOPER
ASSISTANT STATE REGISTRAR
DEPARTMENT OF HEALTH AND
HUMAN SERVICES

STATE OF NEBRASKA - DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF DEATH

11 29742

1. DECEDENT'S NAME (First, Middle, Last, Suffix) Julius Adrian Nemeč		2. SEX Male		3. DATE OF DEATH (Mo., Day, Yr.) Nov. 17, 2011	
4. CITY AND STATE OR TERRITORY, OR FOREIGN COUNTRY OF BIRTH Prague, Nebraska		5a. AGE-Last Birthday (Yrs.) 85		5b. UNDER 1 YEAR MO. DAY HOURS MIN. NO	
7. SOCIAL SECURITY NUMBER 506-48-4982		8a. PLACE OF DEATH HOSPITAL: <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Other (Specify) _____		8b. UNDER 1 DAY HOURS MIN. NO	
8b. FACILITY NAME (If not institution, give street and number) Fremont Area Medical Center		9. COUNTY OF DEATH Dodge		6. DATE OF BIRTH (Mo., Day, Yr.) Sept. 28, 1926	
10. CITY OR TOWN OF DEATH (Include Zip Code) Fremont 68025		11. RESIDENCE STATE Nebraska		12. COUNTY Dodge	
13. STREET AND NUMBER 910 Cottonwood St.		14. CITY OR TOWN North Bend		15. ZIP CODE 68649	
16. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		17. NAME OF SPOUSE (First, Middle, Last, Suffix) If wife, give maiden name. Marilyn L. Harms		18. INVOICE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
19. FATHER'S NAME (First, Middle, Last, Suffix) Joseph Nemeč		20. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Dolezal		21. LICENSURE NO. 11946	
22. EVER IN U.S. ARMED FORCES? (Give dates of service if yes.) Yes, 1/11/51-10/10/52		23. INFORMANT NAME Marilyn Nemeč		24. RELATIONSHIP TO DECEDENT Wife	
25. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Donation <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal <input type="checkbox"/> Other (Specify) _____		26. CEASED TO BE BURIED 11/17/2011		27. DATE (Mo., Day, Yr.) Nov. 21, 2011	
28. CEMETERY, CREMATORY OR OTHER LOCATION Cedar Hill Cemetery, Morse Bluff, Nebraska		29. CITY/TOWN North Bend		30. STATE NE	
31. FUNERAL HOME NAME AND MAILING ADDRESS (Street, City or Town, State) Moser Memorial Chapel, 1040 North Main, North Bend, NE		32. ZIP CODE 68649		33. CAUSE OF DEATH (Do not include date and time of death)	
18. 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 terminal exhaustion without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.					
IMMEDIATE CAUSE: onset to death					
INTERMEDIATE CAUSE (Final phase of condition resulting in death) DUE TO, OR AS A CONSEQUENCE OF: onset to death					
Essentially final condition, 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. onset to death					
19. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
20. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year					
21a. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		21b. IF TRANSPORTATION INJURY <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		21c. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22a. DATE OF INJURY (Mo., Day, Yr.)		22b. TIME OF INJURY		22c. PLACE OF INJURY (At home, farm, street, factory, office building, construction site, etc. (Specify))	
23. DATE OF INJURY (Mo., Day, Yr.)					
24. LOCATION OF INJURY - STREET & NUMBER, APT. NO., CITY/TOWN, STATE, ZIP CODE					
23a. DATE OF DEATH (Mo., Day, Yr.) 11-17-2011		23b. TIME OF DEATH 8:47 AM		24a. DATE SIGNED (Mo., Day, Yr.) 11/17/2011	
23c. DATE SIGNED (Mo., Day, Yr.) 11/17/2011		23d. TIME SIGNED 8:47 AM		24b. TIME OF DEATH (M)	
23e. TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED. (Signature and Title) ✓ Stanley S. Cooper		23f. SIGNATURE OF CORONER, PHYSICIAN OR COUNTY ATTORNEY ONLY		24c. TIME PHONOUNCED DEAD (M)	
24. 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 and Title) ✓ Stanley S. Cooper		25. HAS ORGAN OR TISSUE DONATION BEEN CONSIDERED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. DID TOBACCO USE CONTRIBUTE TO THE DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. WAS CONSENT OBTAINED? No. Applicable if 25a is no <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27. NAME, TITLE AND ADDRESS OF CERTIFIER (PHYSICIAN, PHYSICIAN ASSISTANT, CORONER'S PHYSICIAN OR COUNTY ATTORNEY) (Type or Print) Stanley S. Cooper 2450 HEALTHY WAY FREMONT NE 68025	
28. REGISTRAR'S SIGNATURE Stanley S. Cooper		29. DATE FILED BY REGISTRAR (Mo., Day, Yr.) NOV 28 2011			