

COUNTER ah CE ah
VERIFY ah DE ah
PROOF P
FEES \$ 116.00
CHECK # 10478
CHG _____ CASH _____
REFUND _____ CREDIT _____
SHORT _____ NCR _____

FILED SARPY COUNTY NEBRASKA
INSTRUMENT NUMBER

2014-20733

09/17/2014 11 16 05 AM

Lloyd J. Dowding

REGISTER OF DEEDS



lots 1, 2 & 4 Neitzels Corner, Sarpy County, Nebraska.



**THIS PAGE ADDED
FOR RECORDING
INFORMATION.**

**DOCUMENT STARTS ON
NEXT PAGE.**

LLOYD J. DOWDING

SARPY COUNTY REGISTER OF DEEDS
Steven J. Stastny, Deputy
1210 GOLDEN GATE DRIVE, # 1230
PAPILLION, NE 68046-2842
402-593-5773

*R&R
Joyce Neitzel
P.O. BOX 191
Springfield, Ne
68059*

STATE OF NEBRASKA

2014-20733A

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

OCT 05 2009
LINCOLN, NEBRASKA

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

STATE OF NEBRASKA - DEPARTMENT OF HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT DIVISION
CERTIFICATE OF DEATH 09 28606

1 DECEDENT'S NAME (First, Middle, Last Suffix) Rose Marie Neitzel			2 SEX Female	3 DATE OF DEATH (Mo., Day, Yr.) September 10, 2009
4 CITY AND STATE OR TERRITORY OR FOREIGN COUNTRY OF BIRTH Omaha, Nebraska		5a AGE Last Birthday (Yrs.) 79	5b UNDER 1 YEAR MOS DAYS	5c UNDER 1 DAY HOURS MINS
6 DATE OF BIRTH (Mo., Day, Yr.) May 2, 1930		7 SOCIAL SECURITY NUMBER [REDACTED]		
8a PLACE OF DEATH HOSPITAL		8b FACILITY-NAME (If not institution give street and number) 250 North 7th Street		
8c CITY OR TOWN OF DEATH (Include Zip Code) Springfield		8d COUNTY OF DEATH Sarpy		
9a RESIDENCE STATE Nebraska		9b COUNTY Sarpy		9c CITY OR TOWN Springfield
9d STREET AND NUMBER 250 North 7th Street		9e APT NO.	9f ZIP CODE 68059	9g INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10a MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		10b NAME OF SPOUSE (First, Middle, Last, Suffix) if wife give maiden name Donald Neitzel		
11 FATHER'S NAME (First, Middle, Last, Suffix) Carl - Gottsch		12 MOTHER'S NAME (First, Middle, Maiden Surname) Jessie - Critchfield		
13 EVER IN U.S. ARMED FORCES? Give dates of service if yes (Yes no, or unk) No		14a INFORMANT NAME Donald Neitzel		14b RELATIONSHIP TO DECEDENT Husband
15 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)		16a EMBALMER SIGNATURE <i>Boyd R. Brammer</i>		16b LICENSE NO. 11A5
16c CEMETERY, CREMATORY OR OTHER LOCATION Springfield Cemetery		16d CITY/TOWN Springfield		16e STATE Nebraska
17a FUNERAL HOME NAME AND MAILING ADDRESS (Street, City or Town, State) Kahler-Dolce Mortuary 441 North Washington Street Papillion NE				17b Zip Code 68046-2231
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 ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST				APPROXIMATE INTERVAL onset to death immediate onset to death onset to death onset to death
(a) Cerebrovascular Accident				
(b) DUE TO, OR AS A CONSEQUENCE OF				
(c) DUE TO OR AS A CONSEQUENCE OF				
(d) DUE TO OR AS A CONSEQUENCE OF				
18 PART II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not resulting in the underlying cause given in PART I Atrial Fibrillation				19 WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20 IF FEMALE <input checked="" 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)
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)	
22d INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		22e DESCRIBE HOW INJURY OCCURRED		
22f LOCATION OF INJURY STREET & NUMBER, APT NO		CITY/TOWN	STATE	ZIP CODE
23a DATE OF DEATH (Mo., Day, Yr.) September 10, 2009		23b DATE SIGNED (Mo., Day, Yr.) September 15, 2009		23c TIME OF DEATH 8:14 A.M.
24a DATE SIGNED (Mo., Day, Yr.)		24b TIME OF DEATH		
24c PRONOUNCED DEAD (Mo., Day, Yr.)		24d TIME PRONOUNCED DEAD		
24e 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) <input checked="" type="checkbox"/>				
25 DID TOBACCO USE CONTRIBUTE TO THE DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN		26a HAD ORGAN OR TISSUE DONATION BEEN CONSIDERED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26b WAS CONSENT GRANTED? Not Applicable if 26a is NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27 NAME, TITLE AND ADDRESS OF CERTIFIER (PHYSICIAN, CORONER'S PHYSICIAN OR COUNTY ATTORNEY) (Type or Print) Fredrick J. Schwartz, 11109 S 84th St, Papillion, NE 68046				
28a REGISTRAR'S SIGNATURE <i>Stanley S. Cooper</i>			28b DATE FILED BY REGISTRAR (Mo., Day, Yr.) OCT 1 2009	