



201604428

Carol Livens
Carol Givens

Register of Deeds
DODGE COUNTY, NE

201604428

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Cover Page

LEGAL DESCRIPTION

The Northeast Quarter of the Northeast Quarter of Section 5, Township 17 North, Range 8 East of the 6th P.M., Dodge County, Nebraska; and

The Northwest Quarter of the Northwest Quarter of Section 4, Township 17 North, Range 8 East of the 6th P.M., Dodge County, Nebraska, **except and excluding** a tract of land in said Northwest Quarter of the Northwest Quarter containing 10.51 acres more or less being more particularly described as follows:

Commencing at the Northwest Corner of said NW $\frac{1}{4}$ NW $\frac{1}{4}$, said point being the point of beginning, and going thence N90°00'00"E on an assumed bearing along the North Margin of said NW $\frac{1}{4}$ NW $\frac{1}{4}$ for a distance of 644.70 feet; thence S00°45'25"W, parallel to the West Margin of said NW $\frac{1}{4}$ NW $\frac{1}{4}$, for distance of 710.0 feet; thence S90°00'00"W, parallel to the North Margin of said NW $\frac{1}{4}$ NW $\frac{1}{4}$, for distance of 644.70 feet to a point on the West Margin of said NW $\frac{1}{4}$ NW $\frac{1}{4}$; thence N00°45'25"E along said West Margin for a distance of 710.00 feet to the point of beginning. Said tract being subject to Public Road Right of Way along the North Margin of said tract.

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

07/09/2015
LINCOLN, NEBRASKA

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

STATE OF NEBRASKA - DEPARTMENT OF HEALTH AND HUMAN SERVICES
CERTIFICATE OF DEATH 15 24619

To Be Completed/Verified by: FUNERAL DIRECTOR	1. DECEDENT'S NAME (First, Middle, Last, Suffix) Robert E Knoell		2. SEX Male		3. DATE OF DEATH (Mo., Day, Yr.) June 27, 2015	
	4. CITY AND STATE OR TERRITORY, OR FOREIGN COUNTRY OF BIRTH Fremont, Nebraska		5a. AGE-Last Birthday (Yrs.) 89		5b. DATE OF BIRTH (Mo., Day, Yr.) July 27, 1925	
	7. SOCIAL SECURITY NUMBER 605-34-4289		8a. PLACE OF DEATH HOSPITAL <input type="checkbox"/> Inpatient OTHER <input checked="" type="checkbox"/> Nursing Home LTC <input type="checkbox"/> Hospice Facility <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Decedent's Home <input type="checkbox"/> DQA <input type="checkbox"/> Other (Specify)			
	8b. FACILITY NAME (If not Institution, give street and number) Nye Legacy Health & Rehabilitation Center		8c. CITY OR TOWN OF DEATH (Include Zip Code) Fremont 68025			
	9a. RESIDENCE-STATE Nebraska		9b. COUNTY Dodge		9c. CITY OR TOWN Fremont	
	9d. STREET AND NUMBER 655 West 23rd Street		9e. APT. NO. 513		9f. ZIP CODE 68025	
	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"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown			
	10b. NAME OF SPOUSE (First, Middle, Last, Suffix) If wife, give maiden name. Beverly Soderling		11. FATHER'S NAME (First, Middle, Last, Suffix) Frank Knoell			
	11. FATHER'S NAME (First, Middle, Last, Suffix) Frank Knoell		12. MOTHER'S NAME (First, Middle, Maiden Surname) Marguerite Gannon		14b. RELATIONSHIP TO DECEDENT Spouse	
	13. EVER IN U.S. ARMED FORCES? Give dates of service if Yes. (Yes, No, or Unk) No		14a. INFORMANT NAME Beverly Knoell		15. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Reinterment <input type="checkbox"/> Other (Specify)	
16a. EMBALMER SIGNATURE Not Embalmed		16b. LICENSE NO.		16c. DATE (Mo., Day, Yr.) June 29, 2015		
16d. CEMETERY, CREMATORY OR OTHER LOCATION Elmore Crematory		CITY/TOWN Omaha		STATE Nebraska		
17a. FUNERAL HOME NAME AND MAILING ADDRESS (Street, City or Town, State) Ludvigsen Mortuary, 1249 E 23rd Street, Fremont, Nebraska					17b. Zip Code 68025	
CAUSE OF DEATH (See instructions and examples)						
14. PART I. Enter the <u>chain of events</u> , injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventilator disconnection without showing the violation, COST ABREVIATIONS: SOB=only one cause on the ACCIDENTAL box if necessary.					APPROXIMATE INTERVAL	
IMMEDIATE CAUSE (Final disease or condition resulting in death) a) Dehydration					onset to death hours	
Sequently list conditions, if any, leading to the cause listed on line a. b) Anorexia					onset to death 5 days	
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST c) CVA					onset to death ~10 days	
18. PART II. OTHER SIGNIFICANT CONDITIONS-Conditions contributing to the death but not resulting in the underlying cause given in PART I.					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
21d. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		22a. DATE OF INJURY (Mo., Day, Yr.)		22b. TIME OF INJURY M		22c. PLACE OF INJURY-At home, farm, street, factory, office building, construction site, etc. (Specify)
22d. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		22e. DESCRIBE HOW INJURY OCCURRED				
22. LOCATION OF INJURY - STREET & NUMBER, APT. NO. CITY/TOWN STATE ZIP CODE						
23a. DATE OF DEATH (Mo., Day, Yr.) June 27, 2015		23b. DATE SIGNED (Mo., Day, Yr.) 6-29-15		23c. TIME OF DEATH 2:32 am		24a. DATE SIGNED (Mo., Day, Yr.)
24b. TIME OF DEATH M		24c. PRONOUNCED DEAD (Mo., Day, Yr.)		24d. TIME PRONOUNCED DEAD M		
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)						
25. DID TOBACCO USE CONTRIBUTE TO THE DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN		25a. HAS ORGAN OR TISSUE DONATION BEEN CONSIDERED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25b. WAS CONSENT GRANTED? Not Applicable if 25a is NO <input type="checkbox"/> YES <input type="checkbox"/> NO		
27. NAME, TITLE AND ADDRESS OF CERTIFIER (Type or Print) Thomas A Wolf MD 350 W. 23rd St. Ste A Fremont NE 68025						
28a. REGISTRAR'S SIGNATURE <i>Stanley S. Cooper</i>		28b. DATE FILED BY REGISTRAR (Mo., Day, Yr.) JUL 7 2015				

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