



DCERT 2013126997



DEC 30 2013 13:49 P 2

Nebr Doc Stamp Tax
12-30-2013 Date
\$ Ex017
By PN

Fee amount: 16.00
FB: 61-36635
COMP: PN

Received - DIANE L. BATTIATO
Register of Deeds, Douglas County, NE
12/30/2013 13:49:31.00



2013126997

After recording, please return to:

J. David Beasley
McGrath North Mullin & Kratz, PC LLO,
First National Tower, Suite 3700
1601 Dodge Street, Omaha, NE 68102
(402) 341-3070

TITLE OF DOCUMENT: **CERTIFIED DEATH CERTIFICATE FOR DEEDS**

- Transfer on Death Deed
- Life Estate
- Joint Tenancy
- Other

DEED RECORDED:

October 25, 1978
DATE

Book 1609 Page 456-457
RECORDING INFORMATION

GRANTOR:

BERNARD J. HECK, (Deceased person's name)

GRANTEE(S):

JOAN M. HECK

FULL & COMPLETE LEGAL DESCRIPTION:

LOT 117, IN SOUTHWEST PARK, A SUBDIVISION, IN DOUGLAS COUNTY, NEBRASKA.

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

343903

1. DECEDENT'S NAME (First, Middle, Last, Suffix) Bernard J Heck		2. SEX Male		3. DATE OF DEATH (Mo., Day, Yr.) June 23, 2011	
4. CITY AND STATE OR TERRITORY, OR FOREIGN COUNTRY OF BIRTH Omaha, Nebraska		5a. AGE-Last Birthday (Yrs.) 67	5b. UNDER 1 YEAR MOS. DAYS	5c. UNDER 1 DAY HOURS MINS.	6. DATE OF BIRTH (Mo., Day, Yr.) December 30, 1943
7. SOCIAL SECURITY NUMBER 507-52-4525		8a. PLACE OF DEATH HOSPITAL: <input checked="" type="checkbox"/> Inpatient OTHER: <input type="checkbox"/> Nursing Home/LTC <input type="checkbox"/> Hospice Facility <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Decedent's Home <input type="checkbox"/> DOA <input type="checkbox"/> Other(Specify)			
8b. FACILITY NAME (If not institution, give street and number) Nebraska Medical Center-Clarkson		8c. CITY OR TOWN OF DEATH (Include Zip Code) Omaha 68198		8d. COUNTY OF DEATH Douglas	
9a. RESIDENCE STATE Nebraska		9b. COUNTY Douglas		9c. CITY OR TOWN Omaha	
9d. STREET AND NUMBER 11515 Martha Street		9e. APT. NO.	9f. ZIP CODE 68144	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. Joan M Fagan			
11. FATHER'S NAME (First, Middle, Last, Suffix) Joseph Matthew Heck		12. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve M Hug			
13. EVER IN U.S. ARMED FORCES? Give dates of service if Yes. (Yes, No, or Unk.) Yes 5/13/68-7/8/69		14a. INFORMANT NAME Joan M Heck		14b. RELATIONSHIP TO DECEDENT Wife	
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>[Signature]</i>		16b. LICENSE NO. 1289	16c. DATE (Mo., Day, Yr.) June 27, 2011
16d. CEMETERY, CREMATORY OR OTHER LOCATION Forest Lawn Memorial Park Cemetery		CITY/TOWN Omaha		STATE Nebraska	
17a. FUNERAL HOME NAME AND MAILING ADDRESS (Street, City or Town, State) Heafey-Heafey-Hoffmann-Dworak & Cutler, 7805 W Center Road, Omaha, Nebraska				17b. Zip Code 68124	
CAUSE OF DEATH (See instructions and examples)					
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.				APPROXIMATE INTERVAL	
IMMEDIATE CAUSE: (Final disease or condition resulting in death) a) Subarachnoid Hemorrhage				onset to death 7 days	
DUE TO, OR AS A CONSEQUENCE OF: Sequentially list conditions, if any, leading to the cause listed on line a. b) Respiratory Failure				onset to death 1 days	
DUE TO, OR AS A CONSEQUENCE OF: Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST c)				onset to death	
DUE TO, OR AS A CONSEQUENCE OF: d)				onset to death	
18. PART II. OTHER SIGNIFICANT CONDITIONS-Conditions contributing to the death but not resulting in the underlying cause given in Part I. Hydrocephalus secondary to subarachnoid hemorrhage					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 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.) June 23 2011		23b. DATE SIGNED (Mo., Day, Yr.) June 29, 2011		23c. TIME OF DEATH 1323 m	
23d. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) <i>[Signature]</i>		24a. DATE SIGNED (Mo., Day, Yr.)		24b. TIME OF DEATH m	
23e. 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) <i>[Signature]</i>		24c. PRONOUNCED DEAD (Mo., Day, Yr.)		24d. TIME PRONOUNCED DEAD m	
25. DID TOBACCO USE CONTRIBUTE TO THE DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROBABLY <input checked="" type="checkbox"/> UNKNOWN		26a. HAS 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, PHYSICIAN ASSISTANT, CORONER'S PHYSICIAN OR COUNTY ATTORNEY) (Type or Print) Dr. Thorelli OMC Neurosurgey 982035 NMC Omaha, NE68198					
28a. REGISTRAR'S SIGNATURE <i>[Signature]</i>				28b. DATE FILED BY REGISTRAR (Mo., Day, Yr.) JUL 1 2011	

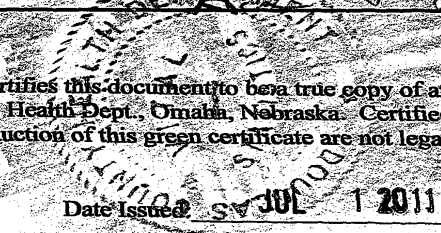
To Be Completed/Verified by: FUNERAL DIRECTOR

To Be Completed by: CERTIFIER

To Be Completed by: MEDICAL CERTIFIER ONLY

To Be Completed by: CORONER'S PHYSICIAN OR COUNTY ATTORNEY ONLY

This certifies this document to be a true copy of an original record on file with Vital Statistics, Douglas County Health Dept., Omaha, Nebraska. Certified copies must have a raised seal in the area to the left. Reproduction of this green certificate are not legal copies.



Date Issued: JUL 1 2011

Registrar: *[Signature]*