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Don Jalta

CLERK OF RECORDS

2001 MAY -4 P 3:55

LANCASTER COUNTY, NE

INST. NO 2001

023474

North 1/2 of the Northeast 1/4 of Section 5, Township 8 North, Range 6 East of the 6th Pm, Lancaster County, Nebraska

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

DATE OF ISSUANCE
FEB 2 1994
LINCOLN, NEBRASKA

Stanley S. Cooper
STANLEY S. COOPER, DIRECTOR
BUREAU OF VITAL STATISTICS

STATE OF NEBRASKA — DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 DECEDENT - NAME FIRST MIDDLE LAST Arthur Orville Reddish, Sr.			2 SEX Male		3 DATE OF DEATH (Month Day Year) January 21, 1994	
4 CITY AND STATE OF BIRTH (If not in U.S.A. name country) Lincoln, Nebraska			5a AGE - Last Birthday (Yrs) 83		6 DATE OF BIRTH (Month Day Year) November 24, 1910	
7 SOCIAL SECURITY NUMBER 505 40 2709			8a PLACE OF DEATH HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):			
8b FACILITY - Name (If not institution, give street and number) Community Care Center			8c CITY TOWN OR LOCATION OF DEATH Waverly			
8d INSIDE CITY LIMITS Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			8e COUNTY OF DEATH Lancaster			
9a RESIDENCE - STATE Nebraska		9b COUNTY Lancaster		9c CITY TOWN OR LOCATION Lincoln		
9d STREET AND NUMBER (Including Zip Code) Rt 1 68502		9e INSIDE CITY LIMITS Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
10 RACE - (e.g. White, Black, American Indian, etc.) (Specify) White		11 ANCESTRY (e.g. Italian, Mexican, German, etc.) (Specify) American		12 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
13 NAME OF SPOUSE (If wife, give maiden name) Lorine D. Giles		14a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				
14b KIND OF BUSINESS INDUSTRY Agriculture		15 EDUCATION (Specify only highest grade completed) Elementary or Secondary (0-12) 12 College (1-4 or 5-)				
16 FATHER - NAME FIRST MIDDLE LAST Oscar D. Reddish			17 MOTHER - NAME FIRST MIDDLE MAIDEN SURNAME Ether Barrett			
18 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or not-K) (If yes, give war and dates of service) No			19a INFORMANT - NAME Lorine Reddish			
19b INFORMANT MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Rt 1, Lincoln, NE 68502						
20a EMBALMER - SIGNATURE & LICENSE NO. <i>Mark Roper</i> 2608		21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Removal <input type="checkbox"/> Cremation <input type="checkbox"/> Donation		21b DATE Febr 1, 1994		
21c CEMETERY OR CREMATORY - NAME Wesley Chapel Cemetery		21d CEMETERY OR CREMATORY LOCATION CITY OR TOWN STATE Rokeby, NE				
22a FUNERAL HOME - NAME ROPER & SONS INC						
22b FUNERAL HOME ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 4300 'O' STREET, LINCOLN, NEBASKA 68510-1791						
23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))						
PART I (a) Myocardial failure				Interval between onset and death Immediate		
(b) Congestive heart failure				Interval between onset and death 12 hours		
(c) Renal failure				Interval between onset and death 2 months		
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related Parkinsonism with dementia			PART III IF FEMALE WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? (Ages 10-54) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		24 AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
25 WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
26a. <input type="checkbox"/> Accident <input type="checkbox"/> Undetermined <input type="checkbox"/> Suicide <input type="checkbox"/> Pending <input type="checkbox"/> Homicide <input type="checkbox"/> Investigation		26b. DATE OF INJURY (Mo., Day, Yr.)		26c. HOUR OF INJURY		
26d. INJURY AT WORK Yes <input type="checkbox"/> No <input type="checkbox"/>		26e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION STREET OR R.F.D. NO. CITY OR TOWN STATE		
27a. DATE OF DEATH (Mo., Day, Yr.) 1/21/94		27b. DATE SIGNED (Mo., Day, Yr.) 1-25-94		27c. TIME OF DEATH 3:30 P.M.		
27d. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. <i>James Carlson M.D.</i>		27e. 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. <i>James Carlson M.D.</i>				
28a. DID TOBACCO USE CONTRIBUTE TO THE DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN		28b. HAS ORGAN OR TISSUE DONATION BEEN CONSIDERED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. WAS CONSENT GRANTED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
29 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, CORONER'S PHYSICIAN OR COUNTY ATTORNEY) (Type or Print) James Carlson, M.D.						
30a REGISTRAR <i>M. J. Jalta</i>			30b DATE FILED BY REGISTRAR (Mo., Day, Yr.) FEB 01 1994			

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