



**CITY OF TRENTON  
DIVISION OF HEALTH  
ROOM 214 CITY HALL  
PHONE (609) 989-3236**



*This is to certify that the following is a true copy  
of a record filed in this department.*

*Date of issue APR 13 1987*

*E. J. L. [Signature]*  
**REGISTRAR OF VITAL STATISTICS**

**WARNING: Do not accept this copy unless the raised seal of the  
Registrar of Vital Statistics is affixed hereon.**

**NEW JERSEY STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH**

1. NAME OF DECEASED (First) <b>JAKOV</b> (Middle) <b>NEDASHKIWSKYJ</b> (Last)			2. DATE OF DEATH <b>Dec. 19, 1983</b>		<b>83-1828</b>
<b>DECEASED</b>	3a. PLACE OF DEATH (City or Town) <b>Trenton</b>		3b. County <b>Mercer</b>	4a. Residence (No. and St.) <b>962 Lambertton Str.</b>	4b. City or Town <b>Trenton</b>
<b>EMPLOYMENT</b>	5a. Name of Hospital or Institution (If not either, give No. and St.) <b>St. Francis Medical Center</b>		4c. County <b>Mercer</b>	4d. State <b>N.J.</b>	4e. Zip Code <b>08611</b>
<b>PARENTS</b>	5b. If Hospital or Institution, check correct box <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency <input type="checkbox"/> Other:		6. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	7a. Was Deceased ever in U.S. Military If "Yes" enter War and Dates <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7b. War From: _____ To: _____
<b>INFORMANT</b>	8. Sex <b>Male</b>	9. Date of Birth <b>October 7, 1899</b>	10. Age Last Birthday <b>84</b>	11a. Under "1" Year MONTHS    DAYS	11b. Under "1" Day HOURS    MINUTES
<b>DISPOSITION</b>	12a. Birthplace (State or Foreign Country) <b>Ukraine</b>		12b. Citizen of what Country <b>Ukraine</b>	13. Surviving Spouse (If Wife, Maiden Name) <b>Anna Zakuilo</b>	14. Social Security Number <b>206-26-3386</b>
<b>CERTIFIER</b>	15. Race <input checked="" type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> Other (Specify)		16. Ethnic Origin <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Cuban <input type="checkbox"/> Italian <input type="checkbox"/> German	17. Name and Address of Last Employer <b>American University Mass. &amp; Nebraska Ave. Washington, D. C.</b>	
<b>CAUSE OF DEATH</b>	18. Usual Occupation (Kind of work done most of Life - even if retired) <b>Ret. Gardner</b>		19. Kind of Business or Industry <b>University</b>		
<b>DISPOSITION</b>	20. NAME OF FATHER (First) <b>Vasil Nedaslikiuky</b> (Middle) (Last)		21. MAIDEN NAME OF MOTHER (First) <b>Anna Nadaslikiusky</b> (Middle) (Last)		
<b>INFORMANT</b>	21a. Name of Informant <b>Jakov Nedashkiwskyj</b>		21b. Relationship <b>self</b>	21c. Number and Street <b>962 Lambertton St.</b>	21d. City or Town <b>Trenton</b>
<b>CERTIFIER</b>	22a. Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Removal <input type="checkbox"/> Cremation <input type="checkbox"/> Other:		22b. Name of Cemetery or Crematory <b>Riverview Cemetery</b>	22c. City or Town <b>Trenton</b>	22d. State <b>N.J.</b>
<b>CAUSE OF DEATH</b>	23a. Name and Address of Funeral Home <b>WINOWICZ FUNERAL SERVICE 308 Adeline Str. Trenton, New Jersey 08611-2599</b>		23b. Signature of Funeral Director <i>Stanley J. Winowicz</i>	23c. N.J. License No. <b>1722</b>	
<b>CERTIFIER</b>	25a. Name and Address of Certifier - <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Exam. <b>LOUIS G. FARES, MD 1345 KUSER RD TRENTON, NJ. 08619</b>		25b. To the best of my knowledge, death occurred at time, date and place, due to cause(s) stated. Signature: <i>Louis G. Fares, MD</i>	25c. Date Signed <b>12-19-83</b>	
				26a. Hour of Death <b>6:47 AM</b>	26b. Pronounced Dead <b>12-19-83</b>
<b>CAUSE OF DEATH</b>	27a. PART I Immediate Cause <b>a. Arteriosclerotic heart disease</b> Due to or as a consequence of <b>b.</b> Due to or as a consequence of <b>c.</b>		(Enter only one cause per line for (a), (b), and (c). Please print)		27d. If female, was she pregnant at death or any time 90 days prior to death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>CERTIFIER</b>	28. Was Autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		29. Was case referred to Medical Examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>CAUSE OF DEATH</b>	30. Death due to <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Under Investigation <input type="checkbox"/> Other		31a. Describe how Injury occurred	31b. Date of Injury	31c. Hour of Injury