

138675

STATE OF INDIANA
COUNTY OF LAKE

AFFIDAVIT

HENRY J. KOEHLER, being first duly sworn upon his oath, deposes and says:

1. That there will be no administration of the estate of WAVA A. KOEHLER, who died on September 30, 1990

2. That at the time of the death of WAVA A. KOEHLER your Affiant, HENRY J. KOEHLER, and WAVA A. KOEHLER were owners of a parcel of real estate as tenants by the entireties, said parcel of real estate being more particularly described as:

The East 49 fee of Lot 16 in Block 2 in Calumet Lawn Addition to Hammond, as per plat thereof, recorded in Plat Book 17, page 2, in the Office of the Recorder of Lake County, Indiana, commonly known as 913-174th Street, Hammond, Indiana.

32-129-17

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3. Your Affiant further states that there is no Federal Indiana State Inheritance Tax due by virtue of the death of WAVA A. KOEHLER.

4. Your Affiant further states that this Affiant and WAVA A. KOEHLER were husband and wife from the time they acquired said real estate and remained husband and wife until the death of WAVA A. KOEHLER on September 30, 1990.

5. This Affiant is the surviving tenant by the entirety and is the sole owner of said real estate, and this Affidavit is made for the purpose of inducing the County Auditor to change the name of the fee owner of said real estate to: HENRY J. KOEHLER.

6. Further your Affiant sayeth not.

FILED

DEC 12 1990

Henry J. Koehler
HENRY J. KOEHLER

SUBSCRIBED AND SWORN to before me this 4th day of December,

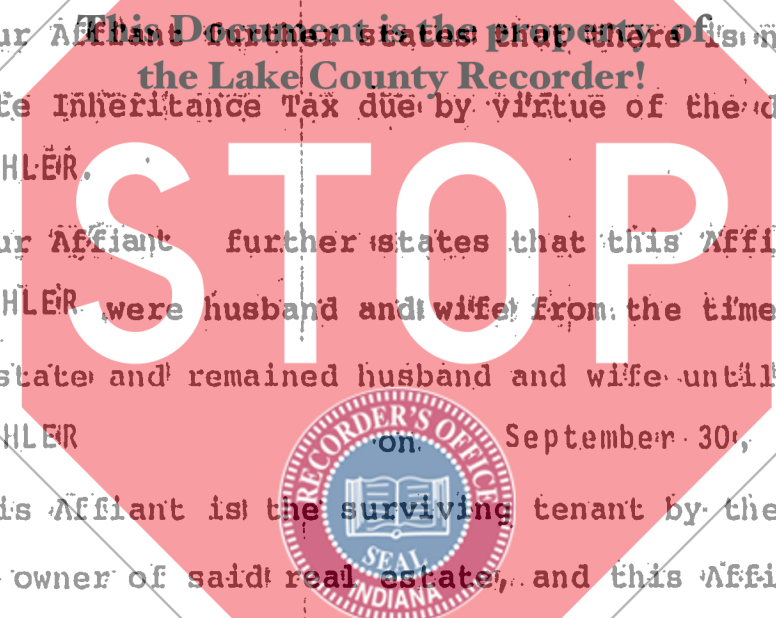
David R. Patton
NOTARY PUBLIC, LAKE COUNTY

Marvin E. Silverman
NOTARY PUBLIC, LAKE COUNTY

MY COMMISSION EXPIRES:
MARVIN E. SILVERMAN
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY.

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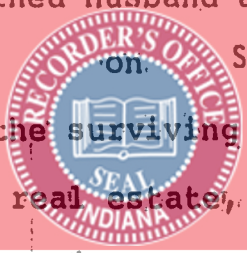
THIS INSTRUMENT PREPARED BY: Marvin E. Silverman, Attorney at Law,
620 W. Chicago Ave., P.O. Box 2116,
East Chicago, IN 46312



This Document is the property of the Lake County Recorder!

DEC 13 10 31 AM '90

STATE OF INDIANA/SS. LAKE COUNTY FILED RECORD



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INDIANA STATE BOARD OF HEALTH

Local No. ... 270

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Wava A. Koehler		7 SEX Female	3a TIME OF DEATH 12:19 P.M.	3b DATE OF DEATH (Month Day Yr) September 30, 1990
4 SOCIAL SECURITY NUMBER 314-26-8989		5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr) Jul. 23, 1913		7 BIRTHPLACE (City and State or Foreign Country) Fairfield Center, IN.		
8a—WAS DECEDENT A US VETERAN? NO	8b YEAR LAST SERVED IN US ARMED FORCES? N/A	9a—PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) St. Catherine Hospital		9c CITY, TOWN OR LOCATION OF DEATH East Chicago	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Henry J. Koehler	17a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker	17b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 913 174th St.	
13e ZIP CODE 46320	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) White
17 DECEDENT'S EDUCATION (Specify, only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) 8				
18 FATHER'S NAME (First Middle Last) Unavailable		19 MOTHER'S NAME (First Middle Maiden Surname) Johnson Adah E. Unavailable		
20a INFORMANT'S NAME (Type/Print) Henry J. Koehler		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 174th St. Hammond, Indiana	20c Relationship Husband	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Type of cemetery, crematory, or other place) October 3, 1990 Chapel Lawn Cemetery	21c LOCATION—City or Town, State Scherverville, Indiana	
22a EMBALMERS NAME Ronald A. Reed		22b EMBALMER'S LICENSE NO. FDO 1001081	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO 101451	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500	
26 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Pulmonary Edema DUE TO (OR AS A CONSEQUENCE OF) Acute Ischemic Heart Disease CONDITIONS, IF ANY, WHICH PRECIPITATED OR CONTRIBUTED TO (OR AS A CONSEQUENCE OF) THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DUE TO (OR AS A CONSEQUENCE OF) DEC 12 1990		Approximate Interval Between Onset and Death		
PART II Other significant conditions, Conditions contributing to death but not previously stated in Part I. None		27a WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO	28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated <input type="checkbox"/> HEALTH OFFICER 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) as stated <input type="checkbox"/> CORONER 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) and manner as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		
29c MEDICAL LICENSE NO. 01035700		29d DATE SIGNED (Month, Day, Year) 10-1-90		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Mansueti H. Silverman M.D. 4320 Fir St., Suite 216 East Chicago, In. 46312				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32 DATE FILED (Month, Day, Year) Oct 01, 1990		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State)				
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

DECEDENT

PARENTS

INFORMANT

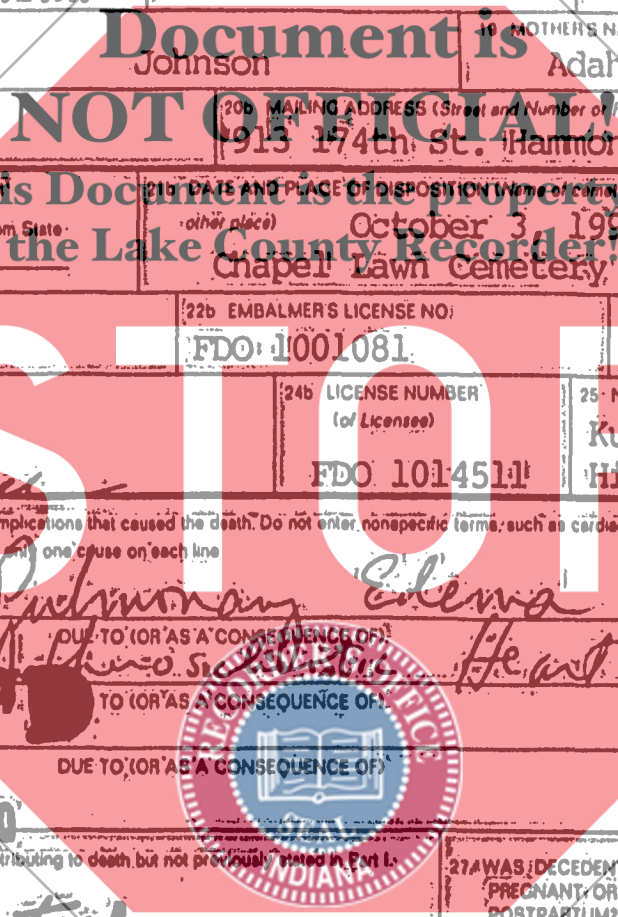
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



38-139-17
 Col. Lawrence A. L. 491 St. 16 St. 2

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