

91023826

RETURN TO: MATTHEW P. DOGAN  
626 W. Ridge Rd. Gary, Ind. 46408

STATE OF INDIANA )

COUNTY OF LAKE )

SS:

SURVIVOR'S AFFIDAVIT

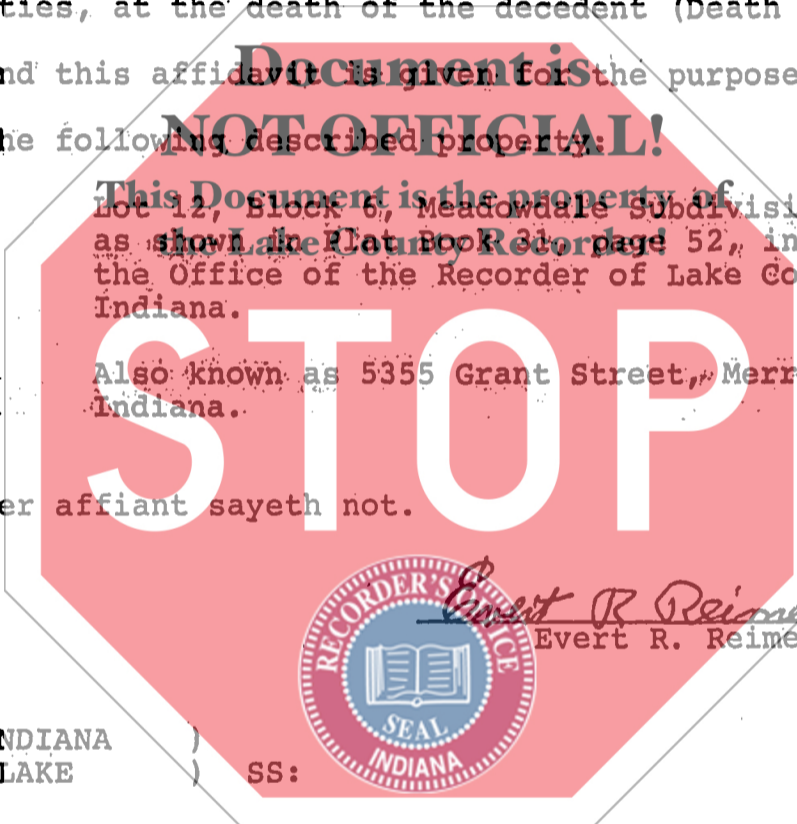
EVERT R. REIMER of the County of Lake, State of Indiana, being duly sworn upon his oath, alleges and says that SHIRLEY REIMER, also known as SHIRLEY J. REIMER, died, intestate, in Lake County, Indiana, on the 26th day of April, 1991; that she was his wife and lived with him to the day of her death as husband and wife. No Federal Estate or Indiana State Inheritance Tax are due and owing due to her death to the best of affiant's knowledge.

The following real estate was owned, as husband and wife by the entireties, at the death of the decedent (Death Certificate attached), and this affidavit is given for the purpose of clearing title to the following described property:

Lot 12, Block 6, Meadowdale Subdivision, as shown in Plat Book R 31, page 52, in the Office of the Recorder of Lake County, Indiana.

Also known as 5355 Grant Street, Merrillville, Indiana.

Further affiant sayeth not.



STATE OF INDIANA/S.S. NO.  
LAKE COUNTY  
FILED FOR RECORD  
MAY 20 9 10 AM '91  
ROBERT J. JOHNSON  
RECORDER OF RECORDS  
DELAND

**FILED**  
MAY 15 1991

*Anna N. Anton*  
AUDITOR LAKE COUNTY

STATE OF INDIANA )  
COUNTY OF LAKE )

SS:

Subscribed and sworn to before me, a Notary Public, in the County of Lake, State of Indiana, this 14th day of May, 1991.

*Matthew P. Dogan*  
Matthew P. Dogan, Notary Public  
Resident of Lake County

My Commission expires:  
January 2, 1994

This instrument prepared by MATTHEW P. DOGAN, ATTORNEY.

800

Re: L. 12, Bl. 6, Meadowdale Sub., Pl. Bk. 31, p. 52, Lake Co., Indiana.  
**PORTER COUNTY BOARD OF HEALTH**  
**CERTIFICATE OF DEATH**  
**THIS DOCUMENT NOT VALID**  
**UNLESS STAMPED ON REVERSE SIDE**

TYPE/PRINT  
 IN  
 PERMANENT  
 BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
 DEATH

CERTIFIER

HEALTH  
 OFFICER

CORONER  
 USE ONLY

1 DECEASED—NAME (First, Middle, Last) <b>SHIRLEY J. REIMER</b>				2 SEX <b>Female</b>		3a TIME OF DEATH <b>12:55 A.M.</b>		3b DATE OF DEATH (Month, Day, Yr.) <b>April 26, 1991</b>							
4 SOCIAL SECURITY NUMBER <b>312-30-4494</b>		5a AGE—Last Birthday (Years) <b>59</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo., Day, Yr.) <b>January 4, 1932</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Kankakee, Illinois</b>					
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES?		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				9b FACILITY NAME (If not institution, give street and number) <b>Whispering Pines Nursing Home</b>				9c CITY, TOWN, OR LOCATION OF DEATH <b>Valparaiso</b>		9d COUNTY OF DEATH <b>Porter</b>	
10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Evert Reimer</b>		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Medical Records Technician</b>				12b KIND OF BUSINESS/INDUSTRY <b>Hospital</b>							
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN, OR LOCATION <b>Merrillville</b>				13d STREET AND NUMBER <b>5355 Grant Street</b>							
13e ZIP CODE <b>46410</b>		13f INSIDE CITY LIMITS? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		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) <b>White</b>		17 DECEASED'S EDUCATION? (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>					
18 FATHER'S NAME (First, Middle, Last) <b>John Jefferson</b>						19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gladys Gerber</b>									
20a INFORMANT'S NAME (Type/Print) <b>Evert R. Reimer</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5355 Grant St. Merrillville, IN 46410</b>				20c Relationship <b>Husband</b>							
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 (Name of cemetery, crematory, or other place) <b>April 29, 1991 Calumet Park Cemetery</b>				21c LOCATION—City or Town, State <b>Merrillville, Indiana</b>							
22a EMBALMER'S NAME <b>William D. Smith</b>				22b EMBALMER'S LICENSE NO. <b>9000049</b>				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 License) <b>1009893</b>				25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410</b>							
26 PART I. Enter the disease, 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) <b>a. Metastatic renal carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF)  b. _____ DUE TO (OR AS A CONSEQUENCE OF)  c. _____ DUE TO (OR AS A CONSEQUENCE OF)  d. _____ DUE TO (OR AS A CONSEQUENCE OF)						Approximate Interval Between Onset and Death <b>9 months</b>									
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.						27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)					
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>						29c MEDICAL LICENSE NO. <b>30965</b>		29d DATE SIGNED (Month, Day, Year) <b>April 29, 1991</b>							
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Michael C. Weiss, M.D., 1101 East Glendale Blvd., Valparaiso, IN 46383 464-2880</b>															
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32 DATE FILED (Month, Day, Year) <b>APRIL 29, 1991</b>									
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		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.											



**FILED**

**MAY 15 1991**

**01003**