160857 Cunningham

Ticor Ho

TICOR TITLE INSURANCE

91040100

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AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Florence Onnen, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Raymond George Onnen died (without leaving a will) (~~leaving a will~~) on Dec 19, 19 90 at Community Hospital

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

27-182-25

Lot 49 in Erie Subdivision, No. 1 of the Industrial Land Company, in the Town of Highland, as per plat thereof, recorded in Plat Book 26 page 36, in the Office of the Recorder of Lake County, Indiana

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STOP
RECORDER'S OFFICE SEAL INDIANA

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (~~her~~) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD
AUG 8 10 44 AM '91
ROBERT(BOB)FREELAND
RECORDER

Further affiant sayeth not.

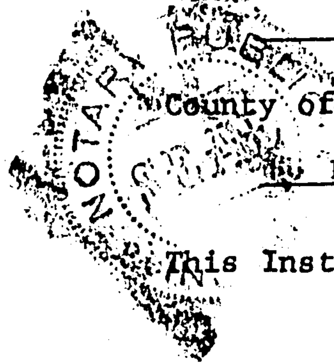
x Florence Onnen
FLORENCE ONNEN

Subscribed and sworn to before me, a Notary Public, this 25th day of July, 19 91.

Linda S. Wood
LINDA S. WOOD Notary Public

My Commission expires:
10-17-94

County of Residence:
Lake



FILED
AUG 07 1991
Anna N. Anton
AUDITOR LAKE COUNTY

This Instrument prepared by Florence Onnen

8.00 tr

00250

Local No. 2570-90

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): RAYMOND GEORGE ONNEN
2. SEX: MALE
3a. TIME OF DEATH: 7:43 A.M.
3b. DATE OF DEATH (Month Day, Yr): DECEMBER 19, 1990
4. SOCIAL SECURITY NUMBER: 345-12-1121
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): JUNE 16, 1913
7. BIRTHPLACE (City and State or Foreign Country): MINONK, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): FLORENCE YARUSINSKY
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): MECHANIC
12b. KIND OF BUSINESS/INDUSTRY: AUTOMOBILE
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HIGHLAND
13d. STREET AND NUMBER: 9832 5th STY
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] 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): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): BENJAMIN ONNEN
19. MOTHER'S NAME (First, Middle, Maiden Surname): THEDA JANNSEN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): FLORENCE ONNEN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9832 5th ST., HIGHLAND, INDIANA 46322
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [XX] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 22, 1990 RIVERVIEW CEMETERY
21c. LOCATION—City or Town, State: STREATOR, ILLINOIS
22a. EMBALMER'S NAME: STEVEN J. STRUCK
22b. EMBALMER'S LICENSE NO.: FD08600181
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL GARDENS, INC. 2828 HIGHWAY AVE. HIGHLAND, IN FH83003035

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Intracerebral Hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

PART II. Other significant conditions - Conditions contributing to death but not resulting in the underlying cause given in Part I
27. 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)

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

DEC 21 1990

[signature] LAKE COUNTY HEALTH COMMISSIONER

FILED AUG 07 1991 — RECORDER'S OFFICE ... INDIANA [seal] — AUDITOR LAKE COUNTY

27-182-25 Key #

CERTIFIER

29a. CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] 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.
[ ] 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: [signature]
29c. MEDICAL LICENSE NO.: 00796
29d. DATE SIGNED (Month, Day, Year): DECEMBER 20 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. STEVEN BAYER, D. O. 1706 RIDGE ROAD MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Robert Gilchrist D.O.
32. DATE FILED (Month, Day, Year): DEC 21, 90

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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.

00251

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1