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TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

PT.A.

91052326

PATRICIA T. AUBRUNER, , being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, William G. Aubruner, Jr. died (without leaving a will) ~~(leaving a will)~~ on February 20 1990 at St. Margaret 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: 35-192-9

West 1/3 of the following described tract: The West 1/2 of Lot 6 and the West 10 feet of the East 1/2 of Lot 6 in Oak Park Addition to Hammond, as per plat thereof, recorded in Plat Book 16 page 10 in the Office of the Recorder of Lake County, Indiana.

OCT 16 8 48 AM '91

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.

Further affiant sayeth not.

Patricia T. Aubruner
PATRICIA T. AUBRUNER,

Subscribed and sworn to before me, a Notary Public, this 25th day of September, 1991.

LINDA S. WOOD Notary Public

My Commission expires:

10-17-94

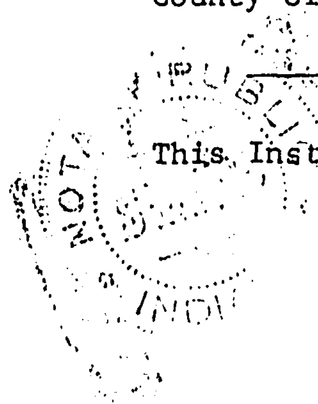
County of Residence:

Lake

FILED

OCT 11 1991

Anna N. Antos
AUDITOR LAKE COUNTY



This Instrument prepared by PATRICIA T. AUBRUNER

00358

8.00

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Aug 28, 1991 — Date Issued

Franklin D. Q... M.D. — Hammond Health Commissioner

Local No. 172

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

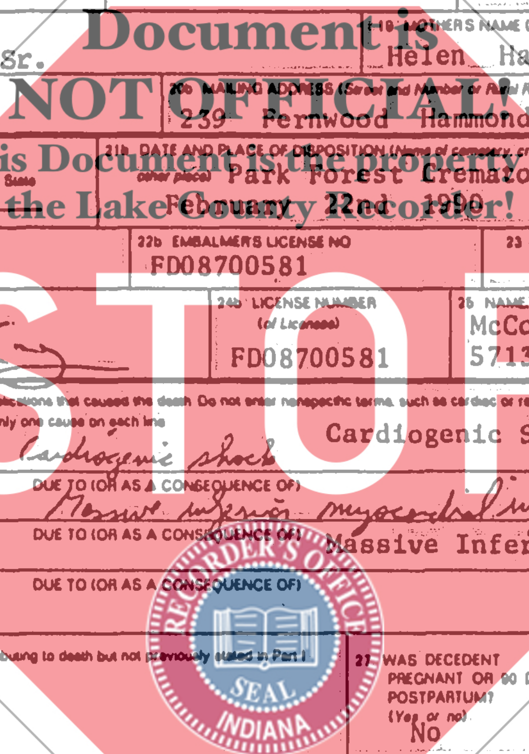
1. DECEASED—NAME (First, Middle, Last): William G. Aubruner Jr.
2. SEX: Male
3a. TIME OF DEATH: 4:20 pm
3b. DATE OF DEATH (Month, Day, Yr): February 20, 1990
4. SOCIAL SECURITY NUMBER: 309-30-7764
5a. AGE—Last Birthday (Years): 58
5b. UNDER 1 YEAR — Months / Days
5c. UNDER 1 DAY — Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): April 8, 1931
7. BIRTHPLACE (City and State or Foreign Country): East Chicago Indiana
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN US ARMED FORCES? 1956
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Patricia Aherai
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Engineer
12b. KIND OF BUSINESS/INDUSTRY: Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 239 Fernwood
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): — College (1-4 or 5+): 4years

PARENTS

18. FATHER'S NAME (First, Middle, Last): William Aubruner, Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Harmon

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Patricia Aubruner
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 239 Fernwood Hammond IN 46324
20c. Relationship: Wife



DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial XX Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Park Forest Crematorium February 22nd 1990
21c. LOCATION—City or Town, State: Park Forest Illinois
22a. EMBALMER'S NAME: David F. McCoy
22b. EMBALMER'S LICENSE NO: FD08700581
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: David F. McCoy
24b. LICENSE NUMBER (of Licensee): FD08700581
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: McCoy Funeral Chapel (287) 5713 Hohman Ave. Hammond IN 46320

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.	Cardiogenic shock (Cardiogenic Shock)	4 days
DUE TO (OR AS A CONSEQUENCE OF) b.	Massive inferior myocardial infarction (Massive Inferior Myocardial Infarction)	4 days
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 previously stated in Part I: Acute renal failure

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): No

CERTIFIER

29a. CERTIFIER (Check only one):
☒ 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: James B. Walsh
29c. MEDICAL LICENSE NO.: 27487
29d. DATE SIGNED (Month, Day, Year): Feb. 2/22/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): James B. Walsh MD 5500 Hohman, Hammond, In 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Q... M.D.
32. DATE FILED (Month, Day, Year): FEB 22 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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 OCT 11 1991

00359

DEA CERT'D RECORDER LAKE COUNTY

Oak Park Add W 40 ft Lot 6 Key#35-192-9, unit 26

161951 T 100R

SBH06 004 State Form 10110 (R2/3-89)