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STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

FEB 23 1992

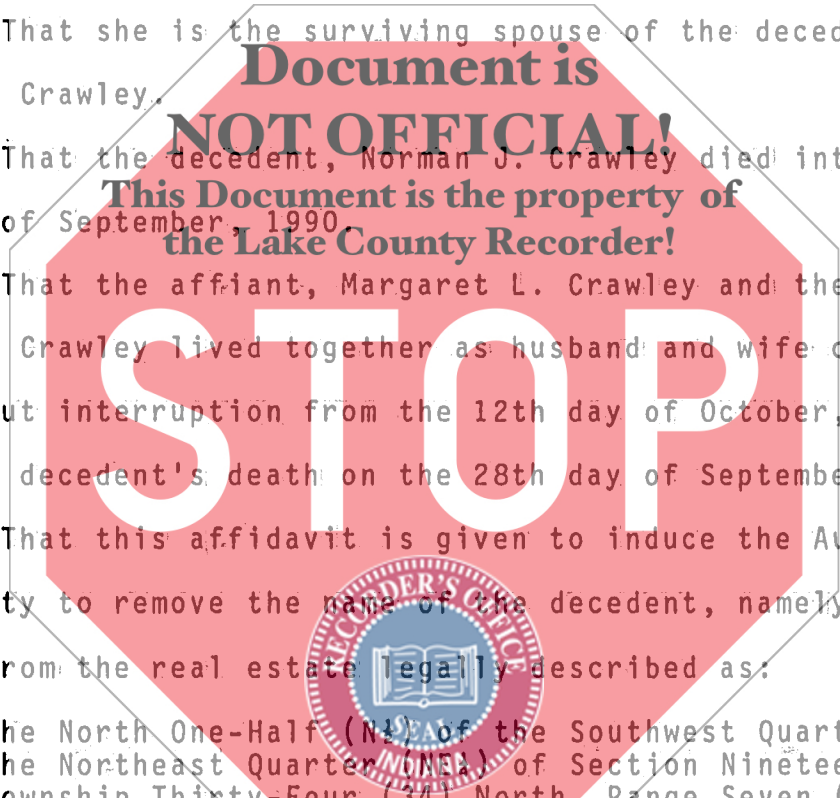
AFFIDAVIT

Margaret L. Crawley, after first being duly sworn upon her oath alleges and says:

1. That she is the surviving spouse of the decedent, Norman J. Crawley.
2. That the decedent, Norman J. Crawley died intestate on the 28th day of September, 1990.
3. That the affiant, Margaret L. Crawley and the decedent, Norman J. Crawley lived together as husband and wife continuously and without interruption from the 12th day of October, 1974 up and until the decedent's death on the 28th day of September, 1990.
4. That this affidavit is given to induce the Auditor of Lake County to remove the name of the decedent, namely Norman J. Crawley from the real estate legally described as:

The North One-Half (N $\frac{1}{2}$) of the Southwest Quarter (SW $\frac{1}{4}$) of the Northeast Quarter (NE $\frac{1}{4}$) of Section Nineteen (19), Township Thirty-Four (34) North, Range Seven (7) West of the Second Principal Meridian in Lake County, Indiana; containing 20 acres, more or less; subject to existing legal highways, ditches and drains, and easements, if any; and subject to applicable zoning regulations. Key # 10-15-10

5. That this affidavit is further given to induce the Auditor



FILED

FEB 23 1992

Gene M. Anton
AUDITOR LAKE COUNTY

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of Lake County to show the name of Margaret L. Crawley as the sole owner of said real estate.

Affiant further sayeth not.

Margaret L. Crawley
MARGARET L. CRAWLEY

SUBSCRIBED AND SWORN TO BEFORE ME, a Notary Public, this 24th day of February, 1992.

Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!

Lisa M. Hancock
Notary Public

My Commission Expires: March 5th, 1994

My County of Residence: Porter



This instrument was prepared by Lisa M. Hancock, Law Office of Vitold Reey, 5681 Broadway, Merrillville, Indiana 46410.



INDIANA STATE BOARD OF HEALTH W2 SUVINE S 19 T 34 R 7
20AC

Local No. 1991:90.....

CERTIFICATE OF DEATH

State No. K54#10.15.10.....
Unit #11

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) NORMAN J. CRAWLEY		2 SEX Male	3a TIME OF DEATH 5:35 p.m.	3b DATE OF DEATH (Month, Day, Year) September 28, 1990
4 SOCIAL SECURITY NUMBER 312-05-6376	5a AGE—Last Birthday (Years) 74	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) November 22, 1915
7 BIRTHPLACE (City and State or Foreign Country) Kirkland, Indiana	8a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
8a WAS DECEDENT A US VETERAN? no	8b YEAR LAST SERVED IN US ARMED FORCES?	9a FACILITY NAME (If not institution, give street and number) St. Anthony Medical Center		
9b CITY, TOWN, OR LOCATION OF DEATH Crown Point		9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Margaret L. Bulmer	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Carpenter	12b KIND OF BUSINESS/INDUSTRY Automotive Industry	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Crown Point	13d STREET AND NUMBER 12707 Gibson St.	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) 12		18 FATHER'S NAME (First, Middle, Last) Orville Crawley		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Ida Johnson		20a INFORMANT'S NAME (Type/Print) Margaret L. Crawley		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12707 Gibson St., Crown Point, IN 46307		20c Relationship Wife		
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) October 1, 1990 Crown Point Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana
22a EMBALMERS NAME Thomas G. Pruzin		22b EMBALMERS LICENSE NO. 1009893		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas G. Pruzin</i>		24b LICENSE NUMBER (of Licensee) 1009893		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Pruzin & Little Funeral Service 830012 811 E. Franciscan Dr., Crown Point, IN 46307
26 PART I: Enter the disease, injury, or complication 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. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. COMPLETE COPY OF THE CERTIFICATE DUE TO (OR AS A CONSEQUENCE OF) DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT				
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. FEB 19 1992				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
		NO		NO
29a. CERTIFIER (Check only one) <input 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 checked="" 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>John G. Horton</i> LAKE COUNTY HEALTH DEPARTMENT		29c. MEDICAL LICENSE NO. 02000632 B		29d. DATE SIGNED (Month, Day, Year) October 1, 1990
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) John G. Horton, D.O. 109 E. North St. Crown Point, Indiana 46307				
31. HEALTH OFFICER'S SIGNATURE <i>John G. Horton</i>				32. DATE FILED (Month, Day, Year) Oct 2 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"/> Could not be Determined <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) FEB 4 1992		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) <i>Yes</i> AUDITOR LAKE COUNTY		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

