5368m

LAWYERS ...
ONE PROFESSIONAL CENTER
SUITE 216
CROWN POINT, IN 46307

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

93028313

I, ELEANOR J. KROLEDGE, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, JOHN KROLEDGE, died leaving a will on April 17, 1993.

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

All of the West Half of the East Half of the Southeast Quarter of the Southwest Quarter of the Northeast Quarter of Section 23, Township 36 North, Range 8 West, of the 2nd Principal Meridian, excepting the South Four Hundred Ninety (490) feet thereof, containing 0.65 acre more or less, subject to an easement over and across the West 30 feet, the North 30 feet and the East 10 feet of said property to be used for street and alley purposes, all in Lake County, Indiana. Commonly known as 3201 Minnesota Street, Lake Station, Indiana 46405.

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD
MAY 4 4 12 PM '93
SAMUEL ORLICH
RECORDER

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 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.

FILED

APR 30 1993

Anna N. Anton
AUDITOR LAKE COUNTY

Eleanor Kroledge
ELEANOR J. KROLEDGE

Subscribed and sworn to before me, a Notary Public, this 19th day of April, 1993.

My Commission Expires:
3-1-95
Resident of Lake County

[signature]
Notary Public

31293 8.00

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0-826-93 — **CERTIFICATE OF DEATH** — State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
JOHN L KROLEDGE	MALE	11:37 PM	APRIL 17, 1993

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
313-18-5211	68			JULY 25, 1924	VALPARAISO, INDIANA

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
YES	1945	HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☒ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST MARY MEDICAL CENTER	HOBART	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
MARRIED	ELEANOR ARCURI	CRANEMAN	U.S STEEL

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	LAKE STATION	3201 Minnesota St

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
46405	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	9 /

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN KROLEDGE	MAUDE FUQUAY

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
ELEANOR J. KROLEDGE	3201 MINNESOTA, LAKE STATION, IN 46405	WIFE

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	APRIL 21, 1993 EVERGREEN MEMORIAL PARK	HOBART INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
TERRENCE P BURNS	1013890	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Terrence P Burns	1013890	Burns Funeral Home, 10101 Broadway, Crown Point, In 46307 FDH83002445

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. Vascular collapse	Unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): b. Duell Lafterios clerotic heart & vascular disease	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II: Other significant conditions — Conditions contributing to death but not previously mentioned

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

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/COMMISSIONER — 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

LAKE COUNTY Chief Deputy ☒ 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
Deborah Huseman	N/A	April 21, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Deborah Huseman, Chief Deputy Coroner — 2293 N. Main, Crown Point, In 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander S. Williams III MD	April 20, 1993

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	01300

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
April 17, 1993	

SDH06-004 State Form 10110 (R3 / 3-92) DEATHCER/PD