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TICOR TITLE INSURANCE

93040634

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Lillian R. Gould, being first duly sworn upon oath, deposes and says:

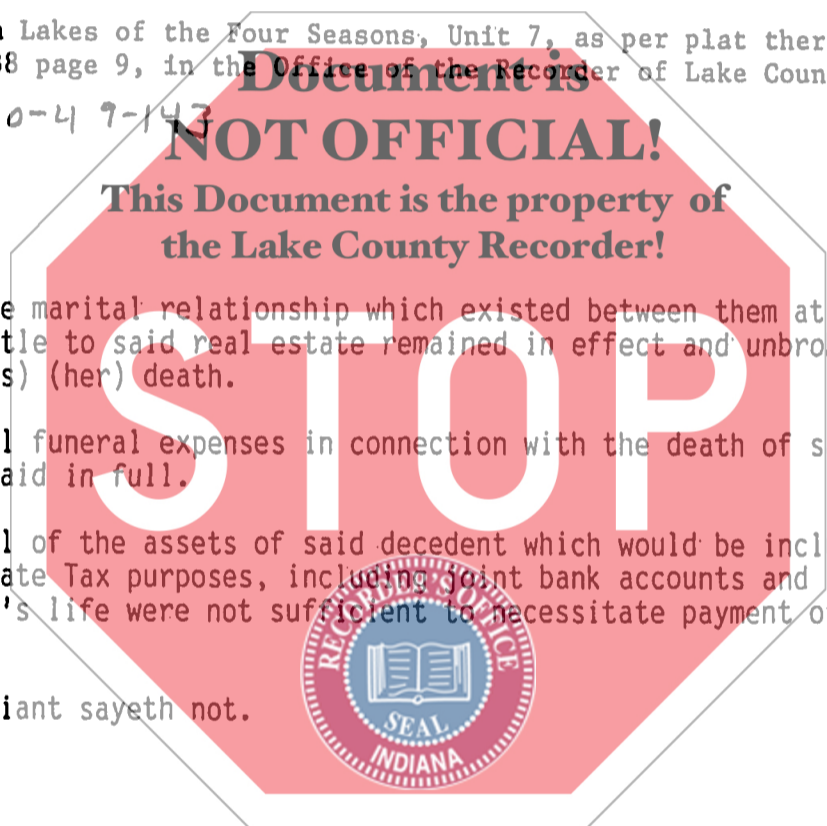
1. That Robert G. Gould died on February 9, 1993 at Crown Point, Indiana

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

Lot 1040 in Lakes of the Four Seasons, Unit 7, as per plat thereof recorded Plat Book 38 page 9, in the Office of the Recorder of Lake County, Indiana.

*# 11-10-47-147

STATE OF INDIANA/S.M.O.
LAKE COUNTY
FILED FOR RECORD
JUN 24 9 59 AM '93
SAMUEL ORRISH
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) (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.

Lillian R. Gould

Lillian R. Gould

Subscribed and sworn to before me, a Notary Public, this 3rd day of June, 1993.

FILED

JUN 17 1993

Gloria Miller
Gloria Miller Notary Public

My Commission expires:
10/24/96

Anna N. Anton
AUDITOR LAKE COUNTY

County of Residence:
Lake

This Instrument prepared by Lillian R. Gould

00476

[Handwritten signature]

6-7-93

Juan/CP/Gm

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

Local No.

TYPE/PRINT IN PERMANENT BLACK-INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

177580 Kirk 0297-93

1 DECEASED—NAME (First, Middle, Last) **ROBERT G. GOULD** 2 SEX **MALE** 3a TIME OF DEATH **11:05 PM** 3b DATE OF DEATH (Month, Day, Year) **FEBRUARY 9, 1993**

4 SOCIAL SECURITY NUMBER **708-01-2628** 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) **May 31, 1915** 7. BIRTHPLACE (City and State or Foreign Country) **LIBERTY, MISS.**

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

9b FACILITY NAME (If not institution, give street and number) **3457 HIGHLAND CT.** 9c. CITY, TOWN OR LOCATION OF DEATH **Crown Point** 9d COUNTY OF DEATH **Lake**

10 MARITAL STATUS (Specify) **MARRIED** 11 SURVIVING SPOUSE (If wife, give maiden name) **Lillian Hendron** 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Yardmaster** 12b KIND OF BUSINESS/INDUSTRY **EJE RAILROAD**

13a RESIDENCE—STATE **Indiana** 13b COUNTY **LAKE** 13c. CITY, TOWN OR LOCATION **Crown Point** 13d STREET AND NUMBER **3457 HIGHLAND CT.**

13e ZIP CODE **46307** 13f. INSIDE CITY LIMITS: No Yes 13g ON A FARM? No Yes 14 CITIZEN OF WHAT COUNTRY? **USA** 15 WAS DECEDENT OF HISPANIC ORIGIN? 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) **10**

18 FATHER'S NAME (First, Middle, Last) **ROBERT GOULD** 19 MOTHER'S NAME (First, Middle, Maiden Surname) **NINA PRODY**

20a INFORMANT'S NAME (Type/Print) **LILLIAN GOULD** 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **3457 HIGHLAND CT., CROWN POINT, IND. 46307** 20c Relationship **WIFE**

21a METHOD OF DISPOSITION Entombment Burial Cremation Removal from State Donation Other (Specify) 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **2-13-93 ST. MARY CEMETERY** 21c. LOCATION—City or Town, State **EVERGREEN PARK, ILL.**

22a EMBALMER'S NAME **JAMES F. BETKOWSKI** 22b. EMBALMER'S LICENSE NO **09200077** 23 WAS DEATH REPORTED TO CORONER? No Yes

24a SIGNATURE OF FUNERAL DIRECTOR *James F. Betkowski* 24b LICENSE NUMBER (of Licensee) **09200077** 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME **BARAN, & SON INC. FHD 83007267 1235 119th St. Whiting, Ind. For Elmwood Chapel Chgo., Ill.**

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. **Congestive Heart Failure** **HEALTH OFFICER'S OFFICE** **FEB 17 1993**

IMMEDIATE CAUSE (Final disease or condition resulting in death) **FILED JUN 17 1993**

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

26. PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I **Anna M. Antons AUDITOR LAKE COUNTY**

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**

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 *John George M.D.* 29c MEDICAL LICENSE NO **01031470** 29d DATE SIGNED (Month, Day, Year) **2/10/93**

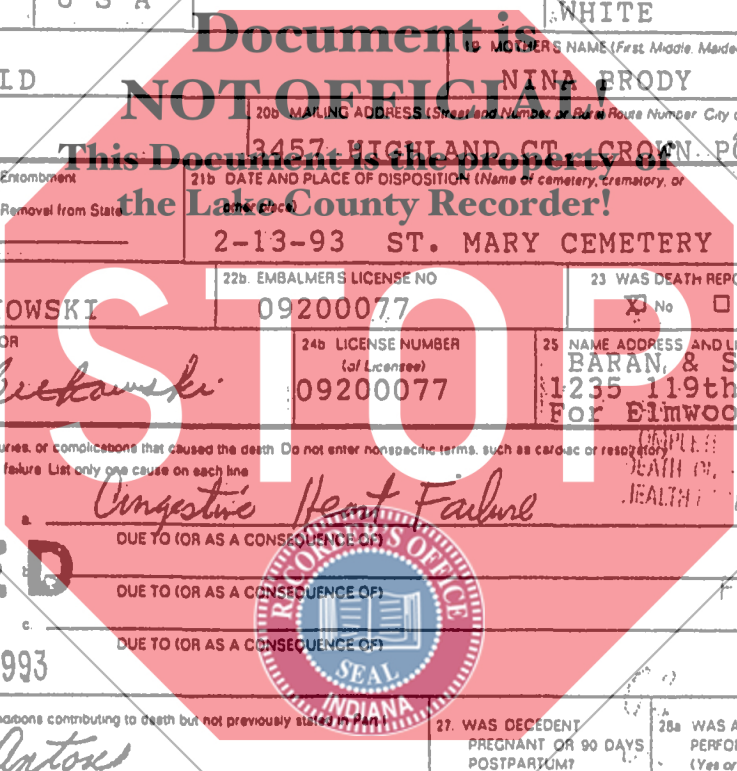
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **JOHN GEORGE, M.D. 7905 Columbus Ave. Munster Ind. 46321**

31 HEALTH OFFICER'S SIGNATURE *Alexander Williams, M.D.* 32. DATE FILED (Month, Day, Year) **FEB 6 11, 1993**

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

34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 34d 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. **00277**



FILED JUN 17 1993