COMMUNITY TITLE COMPANY

— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

COMMUNITY TITLE COMPANY
FILE NO. L 7227

L-7227

93088534

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

RUSSEL W. SCHEIBEL, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, CAROL K. SCHEIBEL died (without leaving a will) (~~leaving a will~~) on January 4, 1991 at St. Margarets 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:

LOT 9 AND THE SOUTH 10 FEET OF LOT 8 IN BLOCK 8 IN WEST PARK ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED AUGUST 17, 1916 IN PLAT BOOK 12 PAGE 35, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, 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.

Further affiant sayeth not.

Russel W. Scheibel
RUSSEL W. SCHEIBEL

Subscribed and sworn to before me, a Notary Public, this 14th day of December, 1993.

Daniel W. Slusser
Notary Public
DANIEL W. SLUSSER

My Commission expires:
8-3-96

County of Residence:
Lake

FILED
DEC 22 1993
Anna N. Anton
AUDITOR LAKE COUNTY

This Instrument prepared by Russel W. Scheibel

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD
DEC 28 10 20 AM '93
SAMUEL ORLICH
RECORDER

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD
DEC 28 2 01 PM '93
SAMUEL ORLICH
RECORDER

NOTARY PUBLIC
LAKE COUNTY

800
01360

RESUBMIT

Local No. ....44.......

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
FEB 13 1989 [signature] M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: FIRST CAROL — MIDDLE JEAN — LAST SCHEIBEL
2 SEX: Female
3 DATE OF DEATH (Mo. Day Yr): January 15, 1989
4 SOCIAL SECURITY NUMBER: 307-40-5145
5a AGE—Last Birthday (Years): 49
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Month, Day, Year): Jan. 25, 1939
7 BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8 YEAR LAST SERVED IN US ARMED FORCES?: Never
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
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—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Russel W. Scheibel
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b KIND OF BUSINESS/INDUSTRY: Own Home
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hammond (Whiting P.O.)
13d STREET AND NUMBER: 2022 Wespark Avenue
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM: No
13g ZIP CODE: 46394
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify
15 RACE—American Indian, Black, White, etc. (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First, Middle, Last): Steven Kristoff
18 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Wargo

INFORMANT

19a INFORMANT'S NAME (Type/Print): Russel W. Scheibel
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2022 Wespark Whiting, IN 46394
19c Relationship: Husband

DISPOSITION

20a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 19, 1989 Elmwood Cemetery
20c LOCATION—City or Town, State: Hammond, Indiana
21a SIGNATURE OF FUNERAL DIRECTOR: Martin Jr. Gabor [signature]
21b LICENSE NUMBER (of Licensee): FDE1040744
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc. FDH3007267 1235-119th, Whiting, IN 46394

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b LICENSE NUMBER
23c DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH
24 TIME OF DEATH: 11:21 A.M.
25 DATE PRONOUNCED DEAD (Month, Day, Year): January 15, 1989
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

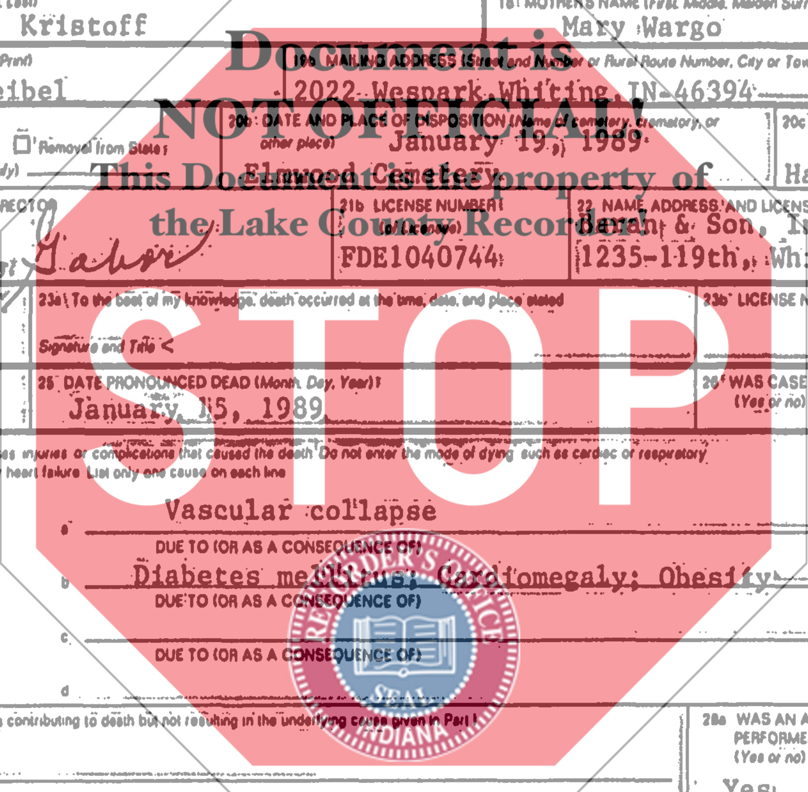
CAUSE OF DEATH (SEE INSTRUCTIONS)

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Vascular collapse — Approximate Interval Between Onset and Death: Unknown
DUE TO (OR AS A CONSEQUENCE OF)
b. Diabetes mellitus; Cardiomegaly; Obesity
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
28a WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes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STOP
RECORDER'S OFFICE SEAL INDIANA

CERTIFIER (SEE INSTRUCTIONS)

29a CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☒ CORONER ☐ 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) and manner as stated.

FILED DEC 22 1993

29b SIGNATURE AND TITLE OF CERTIFIER: Daniel D Thomas M.D. [signature]
29c LICENSE NUMBER: 16120
29d DATE SIGNED (Month, Day, Year): Feb. 6, 1989
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month, Day, Year): FEB 13 1989

CORONER OR MEDICAL EXAMINER 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)

SBH06-004 State Form 10110 Rev. 10/87 DEATH/PD 1

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