

AFFIDAVIT

FILED

SEP 18 1995

**SAM ORLICH
AUDITOR LAKE COUNTY**

95056379

2

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

ARTHUR F. CAMPBELL, BEING FIRST DULY SWORN UPON HIS OATH, DEPOSES AND SAYS:

THAT HE IS A SON OF CATHERINE S. CAMPBELL, WHO WAS THE OWNER OF THE FOLLOWING DESCRIBED REAL ESTATE:

THE SOUTHERLY 21 FEET OF LOT 22 AND THE NORTHERLY 19 FEET OF LOT 23 IN BLOCK 4 IN HIGHLAND TERRACE, IN THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED DECEMBER 2, 1927 IN PLAT BOOK 21 PAGE 80, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 8400 GORDON DRIVE, HIGHLAND, IN. 46322

THAT CATHERINE S. CAMPBELL CONVEYED THE ABOVE DESCRIBED REAL ESTATE TO CAROL KROLL AND CATHERINE S. CAMPBELL, BY WARRANTY DEED RECORDED JANUARY 22, 1991 AS DOCUMENT NO. 91003681.

THAT CATHERINE S. CAMPBELL DEPARTED THIS LIFE ON JULY 13, 1993 AS EVIDENCED BY DEATH CERTIFICATE RECORDED DECEMBER 6, 1993 AS DOCUMENT NO. 93081333.

THAT THE CATHERINE S. CAMPBELL IN WARRANTY DEED RECORDED AS DOCUMENT NO. 91003681, AND THE CATHERINE M. CAMPBELL IN THE DEATH CERTIFICATE RECORDED AS DOCUMENT NO. 93081333, ARE IN FACT, ONE AND THE SAME PERSON.

THAT BECAUSE OF THE NUMBER OF EXEMPTIONS AND THE EXPENSES OF LAST ILLNESS, THERE IS NO INDIANA INHERITANCE TAX DUE AS A RESULT OF THE DEATH OF CATHERINE S. CAMPBELL.

FURTHER AFFIANT SAITH NOT:

Arthur F. Campbell
ARTHUR F. CAMPBELL

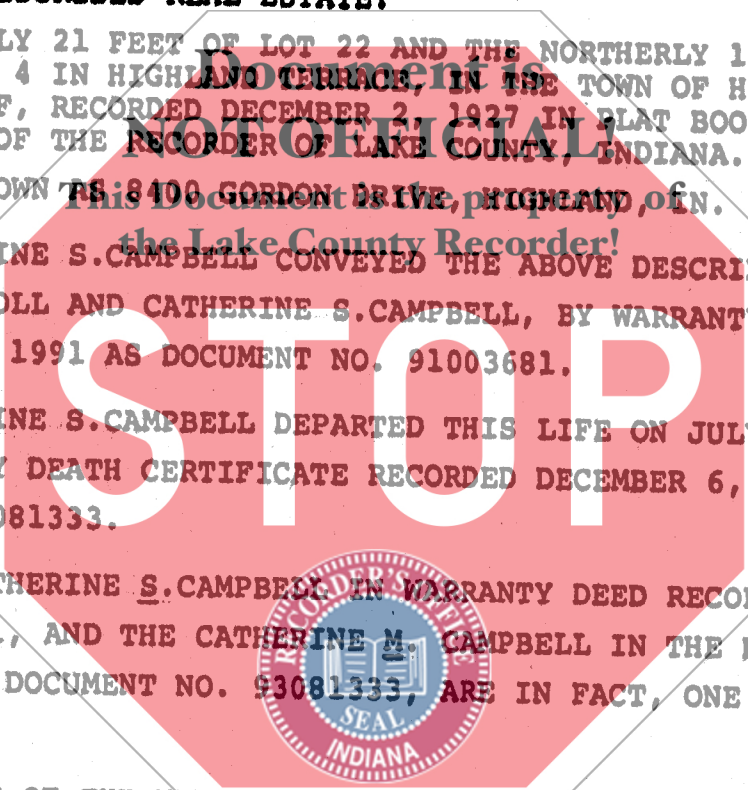
BEFORE ME, THE UNDERSIGNED NOTARY PUBLIC IN AND FOR SAID COUNTY AND STATE, THIS 11th DAY OF September, 19 95 PERSONALLY APPEARED ARTHUR F. CAMPBELL AND ACKNOWLEDGED THE EXECUTION OF THE ABOVE DOCUMENT.

MY COMMISSION EXPIRES: 11/27/98
COUNY OF RESIDENCE : Porter *Martha F. Ornela* NOTARY PUBLIC

THIS INSTRUMENT PREPARED BY: RICHARD PARKS, ATTORNEY AT LAW

1109

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
55 SEP 20 AM 9:23
MARSHALL
RECORDER



930R1333

INDIANA STATE DEPARTMENT OF HEALTH

William L. Collins
Day to Highway Ave
Highland 46303

Local No. 1723-93

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

LAKE C

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) Catherine M. Campbell				2 SEX Female	3a TIME OF DEATH 4:55 A.	3b DATE OF DEATH (Month Day Year) July 13, 1993	
4 SOCIAL SECURITY NUMBER 333-09-9718		5a AGE—Last Birthday (Years) 78	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) May 22, 1915	7 BIRTHPLACE (City and State or Foreign Country) St. Charles, Illinois	
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one (See instructions)) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence					
9b FACILITY NAME (If not institution, give street and number) 8400 Gordon Drive			9c CITY, TOWN OR LOCATION OF DEATH Highland		9d COUNTY OF DEATH Lake		
10 MARITAL STATUS Widowed	11 SURVIVING SPOUSE (If wife, give maiden name) None	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cook			12b KIND OF BUSINESS/INDUSTRY School		
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Highland		13d STREET AND NUMBER 8400 Gordon Dr.	
13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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 birth/highest grade completed) Elementary/Secondary (10-12) 8 College (1-4 or 5 +)	
18 FATHER'S NAME (First Middle Last) Bert Frohling			19 MOTHER'S NAME (First Middle, Maiden Surname) Katherin Krotchvil				
20a INFORMANT'S NAME (Type/Print) Margaret Campbell		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8400 Gordon Dr., Highland, IN 46322			20c Relationship Daughter		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Specify cemetery, or other place) July 16, 1993 Chapel Lawn Cemetery			21c LOCATION—City or Town, State Schererville, Indiana		
22a EMBALMER'S NAME (Type/Print) Ronald A. Reed		22b EMBALMER'S LICENSE NO. FDO1001081		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a COUNTY OF GENERAL RESIDENCY Highland		24b LICENSE NUMBER (of Licensee) FDO1014511		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home FDH3007500 9039 Kleinman Rd., Highland, IN 46322			
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. JUL 14 1993 Advanced Metastatic Carcinoma Rectum						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) Advanced Metastatic Carcinoma Rectum						FILED	
DUE TO (OR AS A CONSEQUENCE OF)							
DUE TO (OR AS A CONSEQUENCE OF)							
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I						NOV 30 1993	
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No			28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO REPORTING OF CAUSE OF DEATH? (Yes or no) N/A		
29. CERTIFIER (Check only one) <input checked="" 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 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.		30. SIGNATURE AND TITLE OF CERTIFIER Moham [Signature]		31. MEDICAL LICENSE NO. 29782		32. DATE SIGNED (Month Day Year) July 13, 1993	
33. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 9116 Columbia Ave., Munster In 46321 M. Ali M.D.							
31. HEALTH OFFICER'S SIGNATURE Alford, Williams, MD					32. DATE FILED (Month Day Year) July 14, 1993		
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) Ali				
34g. DATE PRONOUNCED DEAD (Month Day Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. Ali					

