

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE)

RUSSEL F. BRADY

BEING FIRST DULY SWORN

UPON HIS OATH, DEPOSES AND SAYS:

THAT LORRAINE BRADY DIED ON THE 22nd
DAY OF September, 1995 AT _____

THAT AT THE TIME OF HER DEATH, SHE WAS A CO-OWNER AS A JOINT
TENANT WITH THIS AFFIANT AND ROY J. BRADY AND CAROL L. BRADY

OF THE FOLLOWING DESCRIBED REAL ESTATE:

LOT 15 IN BLOCK 5 IN CLINE GARDENS ADDITION, IN THE CITY OF HAMMOND,
AS PER PLAT THEREOF, RECORDED SEPTEMBER 24, 1956 IN PLAT BOOK 31 PAGE
71, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 6811 NEW HAMPSHIRE, HAMMOND, IN. 46323
UNIT 26 KEY 32-218-15

THAT NO FEDERAL ESTATE TAX OR INDIANA INHERITANCE TAX IS DUE
RESULT OF THE DEATH OF LORRAINE BRADY APR 8 1996

THAT THIS AFFIANT'S RELATIONSHIP TO THE DECEDENT WAS SAM ORLICH
AUDITOR LAKE COUNTY

FURTHER AFFIANT SAITH NOT:

Russel F. Brady

RUSSEL F. BRADY

BEFORE ME THE UNDERSIGNED NOTARY PUBLIC IN AND FOR SAID COUNTY AND

STATE, THIS 29th DAY OF March, 1996, PERSONALLY APPEARED

RUSSEL F. BRADY

AND ACKNOWLEDGED THE

EXECUTION OF THE ABOVE DOCUMENT.

MY COMMISSION EXPIRES:

8-3-96

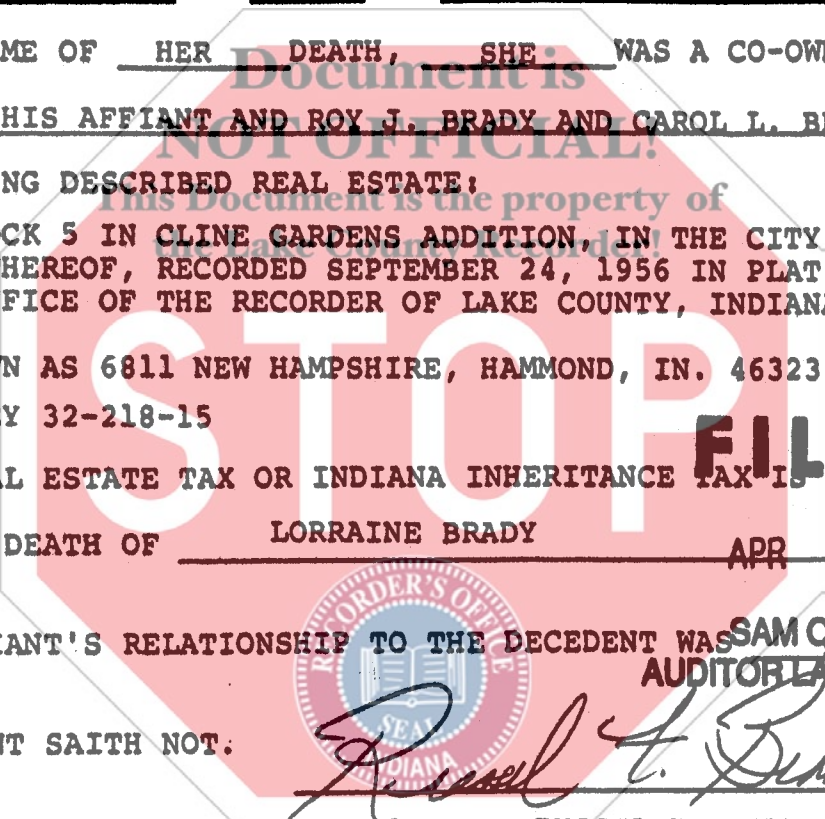
COUNTY OF RESIDENCE: LAKE

THIS INSTRUMENT PREPARED BY: RICHARD PARKS, ATTORNEY AT LAW

DANIEL W SLUSSER
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY
MY COMMISSION EXP. AUG. 3, 1997

NOTARY PUBLIC

000439
RP



960224932

96 APR -9 AM 10:57

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

FILED
APR 8 1996

* ATTENTION ESTATE: The Social Security # is being processed by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2154-95

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IO 10-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

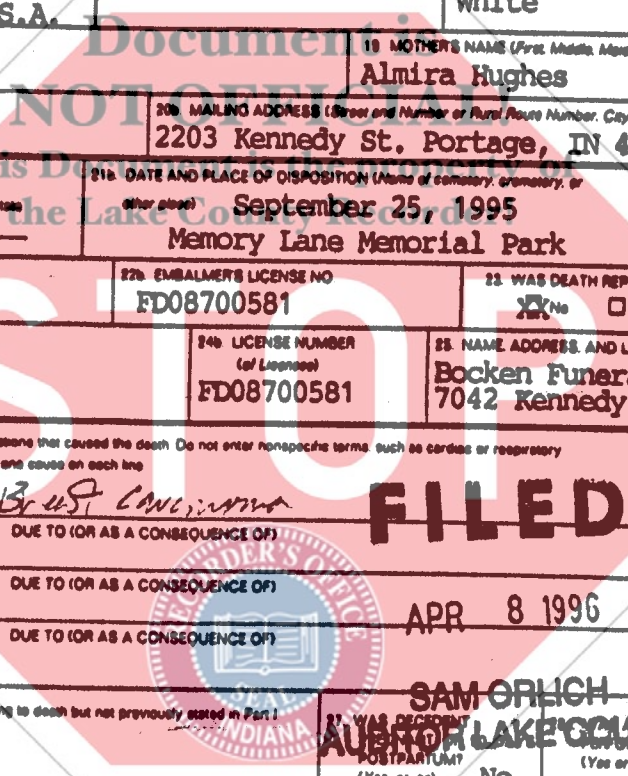
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) LORRAINE BRADY		2 SEX FEMALE	3a TIME OF DEATH 11:50P	3b DATE OF DEATH (Month, Day, Year) SEPTEMBER 22, 1995	
4 SOCIAL SECURITY NUMBER 355-18-7637	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month, Day, Year) September 2, 1925	
7 BIRTHPLACE (City and State or Foreign Country) Turtle Creek, Penn.	8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9 PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not mentioned, give street and number) THE COMMUNITY HOSPITAL		9b CITY, TOWN OR LOCATION OF DEATH MUNSTER	9c 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) Homemaker		12b KIND OF BUSINESS/INDUSTRY Residential	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6811 New Hampshire	
13e ZIP CODE 46323	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 only highest grade completed) Elementary/Secondary (9-12) 12		18			
18 FATHER'S NAME (First, Middle, Last) Frank Snyder		19 MOTHER'S NAME (First, Middle, Maiden Surname) Almira Hughes			
20a INFORMANT'S NAME (Type/Print) Russel F. Brady		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Kennedy St. Portage, IN 46368		20c Relationship Son	
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 (Name of cemetery, crematory, or other place) September 25, 1995 Memory Lane Memorial Park		21c LOCATION—City or Town, State Schererville, IN	
22a EMBALMER'S NAME David F. McCoy		22b EMBALMER'S LICENSE NO. FD08700581		22c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
23a SIGNATURE OF FUNERAL DIRECTOR <i>David F. McCoy</i>		23b LICENSE NUMBER (of Licensee) FD08700581	23c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323		
24 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. Breast Cancer					
25 THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH AS FILED IN THE LAKE COUNTY HEALTH DEPARTMENT (Please Print)					
26a. Conditions of any other cause contributing to death but not previously stated in Part I: Sept. 26, 1995					
27a. SIGNATURE AND TITLE OF HEALTH OFFICER <i>Sam Orlich</i> LAKE COUNTY HEALTH COMMISSIONER		27b. SIGNATURE AND TITLE OF FUNERAL DIRECTOR <i>David F. McCoy</i> AUTHOR LAKE COUNTY		27c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO	
28a. 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.					
28b. SIGNATURE AND TITLE OF CERTIFIER <i>David F. McCoy</i>		28c. MEDICAL LICENSE NO. 33507		28d. DATE SIGNED (Month, Day, Year) SEPTEMBER 25, 1995	
29. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) HOWARD M. MISHOUJLAM, M.D. 9725 PRAIRIE AVENUE HIGHLAND, INDIANA 46322					
30. HEALTH OFFICER'S SIGNATURE <i>Howard M. Mishoujlam</i>				31. DATE FILED (Month, Day, Year) Sept. 26, 1995	
32. 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		32a. DATE OF INJURY (Month, Day, Year)	32b. TIME OF INJURY	32c. INJURY AT WORK? (Yes or no)	32d. DESCRIBE HOW INJURY OCCURRED
33a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		33b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34a. DATE PRONOUNCED DEAD (Month, Day, Year)		34b. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



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