

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

97 APR 17 PM 10: 20

970236  
**TICOR TITLE INSURANCE**

W. CARTER  
RECORDER

AFFIDAVIT

STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

William L. Franz, being first duly  
sworn upon oath, deposes and says:

1. That Kathleen Franz died on  
February 25, 1996 at St. Anthony Medical Center.

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

Lot 6 and the East 25 feet of Lot 7 in Subdivision of Block 4 in Georgia  
Heights Subdivision, as per plat thereof, recorded in Plat Book 29 page 25,  
in the Office of the Recorder of Lake County, Indiana.

This Document is the property of  
the Lake County Recorder! *15-216-6*

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 (1996) (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.

APR 16 1997

**SAM ORLICH**  
**AUDITOR LAKE COUNTY**

William L. Franz  
William L. Franz

Subscribed and sworn to before me, a Notary Public, this 14th day of  
April, 1997.

Paula Barrick  
Paula Barrick Notary Public

My Commission expires:  
10-2-97

County of Residence:  
Lake

000871

This Instrument prepared by William L. Franz

*11.00  
D5-T)*

\* ATTENTION ESTATE: The Social Security # is being requested 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

State No. ....

Local No. 10409-96

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 10-1-103

TYPE/PRINT  
- IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First Middle Last) <b>Kathleen Franz</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>10:05 P.</b>	3b DATE OF DEATH (Month Day Year) <b>February 25, 1996</b>
4 SOCIAL SECURITY NUMBER <b>345-20-7923</b>	5a AGE—Last Birthday (Years) <b>76</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) <b>June 29, 1919</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Dennisop, Ohio</b>	8a WAS DECEDENT A U.S. VETERAN? <b>No</b>			
8b YEAR LAST SERVED IN U.S. ARMED FORCES?		8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> EPO/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution give street and number) <b>St Anthony Medical Center</b>		9b CITY, TOWN OR LOCATION OF DEATH <b>Crown Point</b>		9c COUNTY OF DEATH <b>Lake</b>
10 MARITAL STATUS <b>Married</b>	11 SURVIVING SPOUSE (Last name, first name) <b>William Franz</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>	12b KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Merrillville</b>	13d STREET AND NUMBER <b>840 E. 56th Ave</b>	
13e ZIP CODE <b>46410</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? (No <input type="checkbox"/> Yes <input type="checkbox"/> If yes specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (11-4 or 5+) <b>8</b>		18 FATHER'S NAME (First Middle Last) <b>Fred Wells</b>		
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Zelda Connover</b>		20a INFORMANT'S NAME (Type/First) <b>William L. Franz</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State Zip Code) <b>840 E. 56th Ave Merrillville, IN. 46410</b>		20c Relationship <b>Husband</b>		
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) <b>February 29, 1996 Memory Lane Cemetery</b>		21c LOCATION—City or Town, State <b>Schererville, Indiana</b>
22a EMBALMER'S NAME <b>Lawrence Miller</b>		22b EMBALMER'S LICENSE NO. <b>FDO 1006015</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Lawrence Miller</i>		24b LICENSE NUMBER (of Licensee) <b>FDO 1006015</b>	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Fagen-Miller Funeral Homes Inc 2828 Highway Ave. Highland, IN. 46322</b>	
26 PART I Enter the diseases, injuries or combinations 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. <b>IMMEDIATE CAUSE (First disease or condition resulting in death)</b> <b>Pneumonia / Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Dehydration</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Electrolyte imbalance</b> DUE TO (OR AS A CONSEQUENCE OF)				
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/First) <b>Alberto R. Sanchez 2114-45th St Highland, Indiana 46322</b>				
30 HEALTH OFFICER'S SIGNATURE <i>Alberto R. Sanchez, MD</i>			31 DATE FILED (Month Day Year) <b>February 27, 1996</b>	
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				
33a DATE OF INJURY (Month Day Year)		33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)	
33d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		33e 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.		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

FILED

APR 16 1996

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

FEB 29 1996

SAM ORLICH  
AUDITOR LAKE COUNTY

LAKE COUNTY HEALTH COMMISSIONER

MAILED 96  
FILED  
APR 16 1996  
LAKE COUNTY HEALTH DEPT.

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