

2
FA # 21922

LEGAL DESCRIPTION:

LOT 57 IN BRIAR RIDGE COUNTRY CLUB ADDITION, UNIT ONE, A PLANNED UNIT DEVELOPMENT, IN THE TOWN OF SCHERERVILLE, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 53 PAGE 79, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.



PROPERTY ADDRESS: 1425 St. Andrews Drive
Schererville, IN 46375

FILED

OCT 08 1997

ESTATE AFFIDAVIT

Louis Albert, Affiant, states that:

**SAM ORLICH
AUDITOR LAKE COUNTY**

1. Shirley Albert, deceased, died on the 7th day
of September 19 93.

2. Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the
estate of the deceased;

3. The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;

4. The deceased and Affiant were married on the 22nd day of
August, 1952; and were never divorced.
(This item applies only to the surviving spouse.)

5. All expenses of the last illness and funeral of the deceased have been paid;

6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased
and his/her estate have been paid;

7. There are no claims against the estate of the decedent.

97068191

97 OCT - 8 AM 10: 28

MORRIS W. CARTER
RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

October 3, 1997
Date

Louis Albert
Signature of Affiant

Louis Albert
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 3rd day of October, 19 97.

Kim A. Diaz
Printed Name of Notary

Kim A. Diaz
Signature of Notary

My Commission expires: 2/15/99

My County of Residence is: LAKE COUNTY

000536

THIS INSTRUMENT WAS PREPARED BY: LOUIS ALBERT

FA21922

HOLD FOR FIRST AMERICAN TITLE

12:00 pm
FA

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2194-93

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) Shirley J. Albert		2 SEX Female	3a TIME OF DEATH 10:28A M	3b DATE OF DEATH (Month Day, Yr) September 7, 1993	
4 SOCIAL SECURITY NUMBER 309-34-5117	5a AGE—Last Birthday (Years) 58	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Feb. 26, 1935	
7 BIRTHPLACE (City and State or Foreign Country) Plymouth, Indiana	8a WAS DECEDENT A U.S. VETERAN No	8b YEAR LAST SERVED IN U.S. ARMED FORCES N/A	8c PLACE OF DEATH (Check any one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) Munster Community Hospital		9b CITY TOWN OR LOCATION OF DEATH Munster	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Louis P. Albert	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 Homemaking		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Schereville	13d STREET AND NUMBER 1425 St. Andrews Dr.		
13a ZIP CODE 46375	13b 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		College (1-4 or 5+) <input checked="" type="checkbox"/>			
18. FATHER'S NAME (First Middle Last) Karl Emmons		19. MOTHER'S NAME (First Middle Maiden Surname) Julia Taylor			
20a. INFORMANT'S NAME (Type/Print) Louis P. Albert		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 St. Andrews Dr., Schereville, IN46375	20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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 10, 1993 Bremen Cemetery Mausoleum		21c. LOCATION—City or Town, State Bremen, Indiana	
22a. EMBALMER'S NAME Max Tharpe		22b. EMBALMER'S LICENSE NO. FD 01050569	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Donald J. Williams</i>		24b. LICENSE NUMBER (of License) FD 01012030	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Johnson Funeral Home FH83005590 1100 N. Mich., Plymouth, IN. 46563		
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. Cardiac and Respiratory Failure Sepsis Breast cancer				Approximate Interval Between Onset and Death	
26. PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Chronic Kidney Disease</i>					
27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO REPORTING OF CAUSE OF DEATH? (Yes or no) No		
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER 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.					
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Russell J. Keller</i>		29b. MEDICAL LICENSE NO. 01029020	29c. DATE SIGNED (Month Day, Year) 9/13/93		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 9108 Columbia Ave Munster IN 46321					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander J. Williams MD</i>					
32. DATE FILED (Month Day Year) September 15, 1993					
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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)			
34g. DATE PRONOUNCED DEAD (Month Day Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

FILED

OCT 08 1997

SAM OBLICH + AUDITOR LAKE COUNTY

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