HOLD FOR FIRST AMERICAN

FA- 22457

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

97 DEC 19 AM 10:38

MORRIS W. CARTER
RECORDER

Property Address: 343 North Wr~~ight~~ 9708484
Griffith IN 46319

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

JOSEPH W MARSHALL JR, Affiant, states that:

1. HELEN S. MARSHALL, deceased, died on the 8 day of NOV, 1996;

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 27 day of JUNE, 1962; 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 decendent.;

FILED
DEC 19 1997
SAM ORLICH
AUDITOR LAKE COUNTY

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

Nov Dec 1, 1997
Date

Joseph W Marshall Jr.
Signature of Affiant

JOSEPH W MARSHALL JR.
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 1st day of December, 1997.

Barbara N. Derrico
Printed Name of Notary

Barbara N Derrico
Signature of Notary

My Commission expires: 4/14/2000

My County of Residence is: Lake

BARBARA N DERRICO
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY
MY COMMISSION EXP. APR. 14,2000

001175

11:50 AM

ATTENTION STATE: 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

Local No. 3173-96 State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Helen Marshall
2. SEX: Female
3a. TIME OF DEATH: 1:15 A M
3b. DATE OF DEATH (Month, Day, Yr): November, 8, 1996
4. SOCIAL SECURITY NUMBER: 312-44-2483
5a. AGE—Last Birthday (Years): 52
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): Nov. 12, 1943
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
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 ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): The Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Joseph Marshall
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Owner
12b. KIND OF BUSINESS/INDUSTRY: Learning center
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Griffith
13d. STREET AND NUMBER: 343 N. Wright
13e. ZIP CODE: 46319
13f. INSIDE CITY LIMITS? ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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 (0-12): / College (1-4 or 5 +): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last): James Gallmore
19. MOTHER'S NAME (First, Middle, Maiden Surname): Joan Blackwell

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Joseph Marshall
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 343 N. Wright St. Griffith, Indiana
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 11, 1996 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Edgar Gleim
22b. EMBALMER'S LICENSE NO.: FDO 1016173
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: A Kuiper
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500

CAUSE OF DEATH

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Intracerebral Bleed	10 days
DUE TO (OR AS A CONSEQUENCE OF) b.	Adeno carcinoma of Unknown	unknown
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. DUE TO (OR AS A CONSEQUENCE OF) c.	Mitosis	
d.		

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): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no):

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: T. Vokes, MD
29c. MEDICAL LICENSE NO.: 010 36951
29d. DATE SIGNED (Month, Day, Year): 11-11-96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Vokes Hammond Clinic 7905 Calumet Ave. Munster, IN 46321 (219) 836-5800

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander C. Fellingham, MD
32. DATE FILED (Month, Day, Year): November 13, 1996

THIS CERTIFICATE OF DEATH IS IN THE LAKE COUNTY HEALTH DEPARTMENT

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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

Alexander C. Fellingham, MD
LAKE COUNTY HEALTH COMMISSIONER

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1