FA# 23668

LEGAL DESCRIPTION: LOT ONE HUNDRED FIFTY-TWO (152) MARK SUBDIVISION, IN THE CITY OF EAST CHICAGO, AS SHOWN IN PLAT BOOK 15, PAGE 36, IN LAKE COUNTY, INDIANA.

First American Title Insurance Company

PROPERTY ADDRESS: 505 GROVE ST
EAST CHICAGO, IN

HOLD FOR FIRST AMERICAN TITLE

98023606

ESTATE AFFIDAVIT

DORIS M. BROWN, Affiant, states that:

1. WILLIAM G. BROWN, deceased, died on the 25 day of Jan., 1998;

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 5 day of May, 1934; 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; Yes

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

7. ✓ There are no claims against the estate of the decendent. No

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

March 27, 98
Date

X Doris M. Brown
Signature of Affiant

DORIS M. BROWN
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 31st day of MARCH, 19 98

CORINA CASTEL RAMOS
Printed Name of Notary

My Commission expires: 5/01/98

My County of Residence is: PORTER

CC
Signature of Notary CORINA CASTEL RAMOS

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
98 APR -3 AM 10:

FILED
APR 3 1998
SAM ORLICH
AUDITOR LAKE COUNTY
000275

THIS INSTRUMENT WAS PREPARED BY:

12.00 KM FA

* **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.

Local No. 22

INDIANA STATE DEPARTMENT OF HEALTH

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

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
William G. Brown	Male	8:35 a.m.	January 25, 1998

4. *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr.)	7 BIRTHPLACE (City and State or Foreign Country)
312-10-2363	85			Dec. 21, 1912	Aliquippa, Pennsylvania

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
No	-	HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Catherine Hospital	East Chicago	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Doris M. Lamb	Foreman	L.T.V. Steel Co.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	East Chicago	505 Grove Street

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46312	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	XX No ☐ Yes	White	11	-

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
John Brown	Carrie

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Doris M. Brown	505 Grove Street, East Chicago, IND 46312	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	January 29, 1998 Washington Memorial Gardens	Homewood, Illinois

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
James H. Fife	FD01010795	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
John F. Fife	FD01020366	FIFE FUNERAL HOME - FH83001512 4201 Indpls.Blvd.,E.Chgo, IND

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. Accidental vehicular accident	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

Myocardial insufficiency
coronary artery disease
hypertension

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	-

FILED
APR 3
SAM ORLICH
AUDITOR LAKE COUNTY

CERTIFIER

29a CERTIFIER (Check only one)
XX 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
[signature]	01018389	Jan. 26, 1998

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. Ronald Reed, M.D. - 3641 Ridge Road, Highland, Indiana 46322

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Dr. Timothy Kaykovich	1-27-98

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

000279

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