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STATE OF INDIANA
LAKE COUNTY
PUBLIC RECORDS

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STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

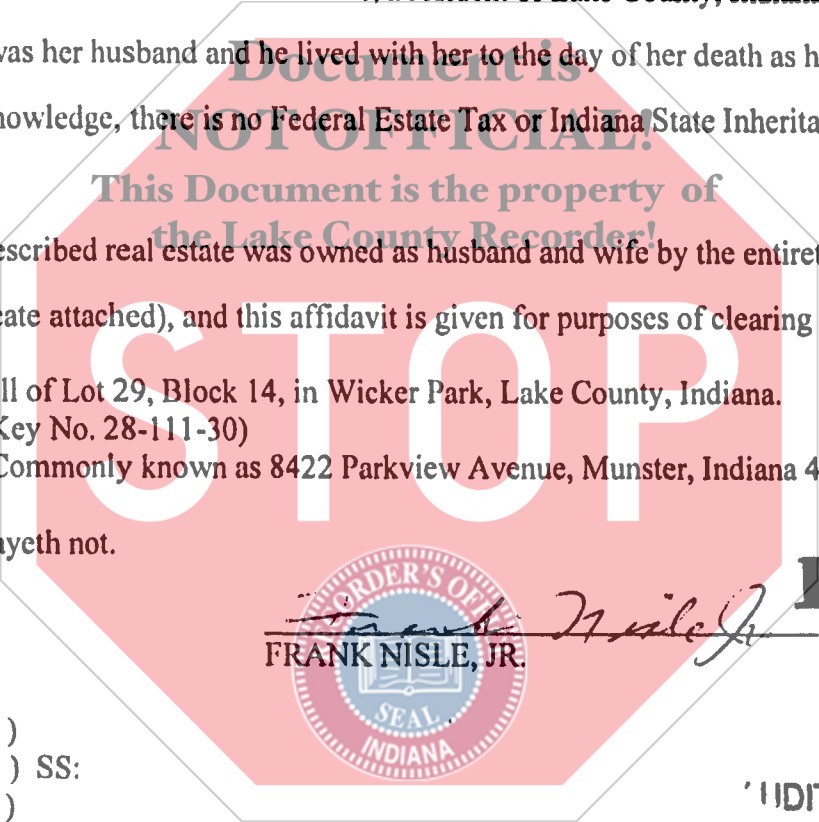
SURVIVOR'S AFFIDAVIT

FRANK NISLE, JR., of the County of Lake, State of Indiana, being duly sworn upon his oath, alleges and says that CHARLOTTE M. NISLE died intestate, a resident of Lake County, Indiana, on the 21st day of October, 1989; that he was her husband and he lived with her to the day of her death as husband and wife; that to the best of affiant's knowledge, there is no Federal Estate Tax or Indiana State Inheritance Tax due and owing due to her death.

The following described real estate was owned as husband and wife by the entireties at the death of the decedent (Death Certificate attached), and this affidavit is given for purposes of clearing title to said real estate:

All of Lot 29, Block 14, in Wicker Park, Lake County, Indiana.
(Key No. 28-111-30)
(Commonly known as 8422 Parkview Avenue, Munster, Indiana 46321.)

Further affiant sayeth not.



Frank Nisle, Jr.
FRANK NISLE, JR.

FILED
JUN 03 1998

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SAM ORLICH
AUDITOR LAKE COUNTY

Subscribed and sworn to before me, a Notary Public for said County and State, this 1st day of June, 1998.

Karen L. Pence
KAREN L. PENCE, Notary Public
Resident of Lake County

My Commission Expires: 4-18-99
RETURN TO: ATTORNEY THOMAS M. DOGAN, 8585 Broadway, Suite 780, Merrillville, IN 46410

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000440

1100 Km
CK# 8960

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 4402-89

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) CHARLOTTE NISLE		2. SEX FEMALE		3a. TIME OF DEATH 11 16 P		3b. DATE OF DEATH (Month, Day, Yr) OCTOBER 21, 1989	
4. SOCIAL SECURITY NUMBER 337-12-2121A		5a. AGE—Last Birthday (Years) 67		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) JUNE 23, 1922		7. BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINIOS					
8a. WAS DECEDENT A US VETERAN? NO		8b. YEAR LAST SERVED IN US ARMED FORCES? NONE		8c. PLACE OF DEATH (Check only 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) 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) FRANK NISLE		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOUSEWIFE		12b. KIND OF BUSINESS/INDUSTRY OWN HOME	
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION MUNSTER		13d. STREET AND NUMBER 8422 PARKVIEW AVE	
13e. ZIP CODE 46321		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 (0-12) 12YRS College (11-4 or 5+)					
18. FATHER'S NAME (First, Middle, Last) EDWARD HORLBECK				19. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA DEECKEN			
20a. INFORMANT'S NAME (Type/Print) FRANK NISLE		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8422 PARKVIEW MUNSTER, INDIANA 46321				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) OCTOBER 25, 1989 CALUMET PARK CEMETERY				21c. LOCATION—City or Town, State MERRILLVILLE, INDIANA	
22a. EMBALMER'S NAME BRIAN BURNS		22b. EMBALMER'S LICENSE NO. 8691763		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) 1021590		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS-KISH FUNERAL HOME 3004968 8415 Calumet Ave MUNSTER, INDIANA			
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. Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Acute Intestinal Bleeding</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Malignant Perforation</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>Metastatic Carcinoma of Endometrium</i> DUE TO (OR AS A CONSEQUENCE OF) d. _____							
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I JUN 03 1990							
27a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> SAM ORLICH DEPUTY HEALTH OFFICER <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		27b. To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. 27c. 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.					
28a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				28b. MEDICAL LICENSE NO. IN 29782		28c. DATE SIGNED (Month, Day, Year) OCT 23 89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MOHAMMAD ALI 9116 COLUMBIA AVE MUNSTER, INDIANA 46321							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) OCT 23, 1989	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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. 000441			

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