

TICOR 2019792

3

# TICOR TITLE INSURANCE

## AFFIDAVIT

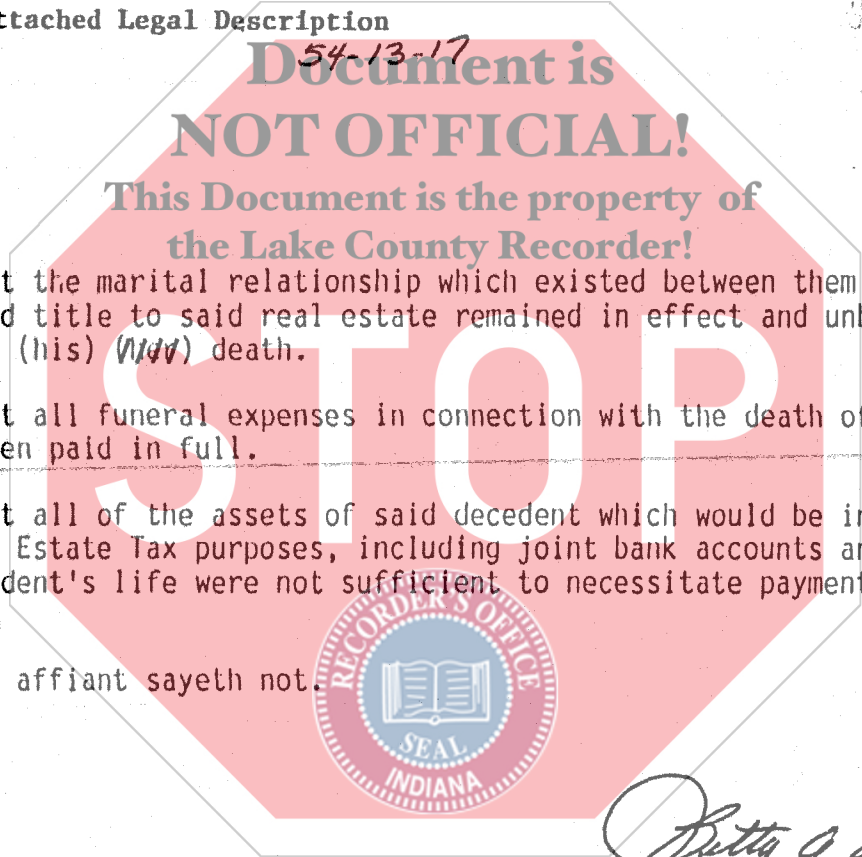
98046046

STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

Betty Ann Weiler, being first duly sworn upon oath, deposes and says:

1. That <sup>BW.</sup> Bruce A. Weiler died on JANUARY 13, 1998 at BROADWAY Methodist.
2. That Bruce A. Weiler and Betty Ann Weiler were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

See Attached Legal Description



STATE OF INDIANA  
LAKE COUNTY  
FILE RECORDER  
JUN 9 AM 9:11  
OPEN W. OFFICE

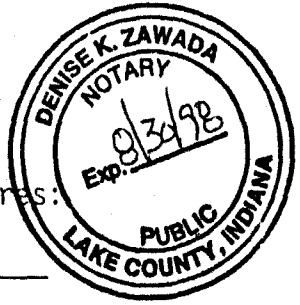
3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (his) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets 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.

Betty Ann Weiler

Betty Ann Weiler

Subscribed and sworn to before me, a Notary Public, this 16th day of June, 1998.



Denise K. Zawada  
Denise K. Zawada Notary Public

My Commission expires: 8/30/98

County of Residence:

Lake

This Instrument prepared by Betty Ann Weiler

**FILED**  
JUN 18 1998

SAM ORLICH  
AUDITOR LAKE COUNTY

001401  
1300  
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c No. CO 219792

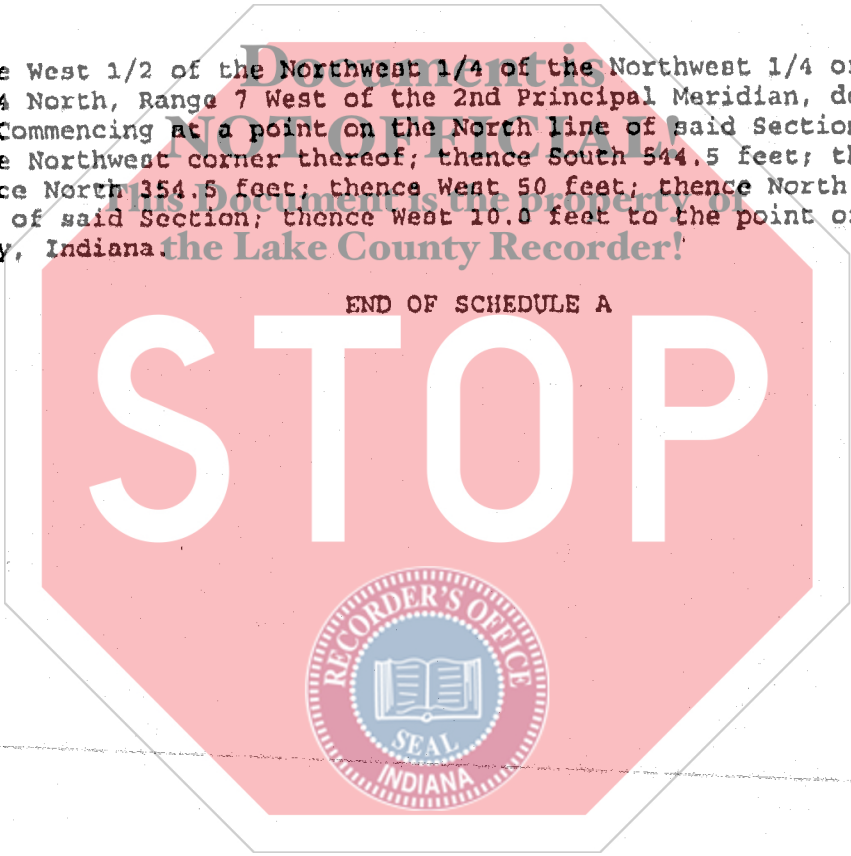
LEGAL DESCRIPTION

PARCEL I:

Part of the West 1/2 of the Northwest 1/4 of the Northwest 1/4 of Section 20, Township 34 North, Range 7 West of the 2nd Principal Meridian, described as follows: Commencing at a point on the North line of said Section 20, 610 feet East of the Northwest corner thereof; thence South 190 feet; thence East 50 feet; thence North 190 feet to the North line of said Section; thence West 50 feet to the point of beginning, in Lake County, Indiana.

PARCEL II:

Part of the West 1/2 of the Northwest 1/4 of the Northwest 1/4 of Section 20, Township 34 North, Range 7 West of the 2nd Principal Meridian, described as follows: Commencing at a point on the North line of said Section 20, 600 feet East of the Northwest corner thereof; thence South 544.5 feet; thence East 60 feet; thence North 354.5 feet; thence West 50 feet; thence North 190 feet to the North line of said Section; thence West 10.0 feet to the point of beginning, in Lake County, Indiana.



END OF SCHEDULE A

10-00  
 \*ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No. ....

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

Local No. 0121-98  
 TYPE/PRINT  
 IN  
 PERMANENT  
 BLACK INK

DECEDENT

PARENTS

INFORMANT

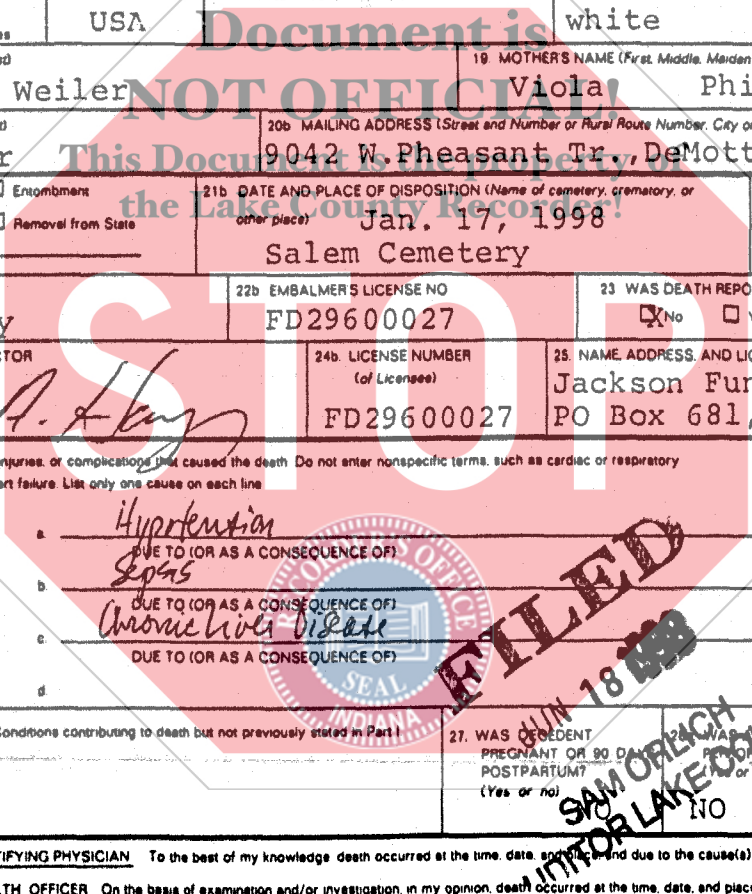
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>BRICE A. WEILER</b>		2. SEX <b>male</b>	3a. TIME OF DEATH <b>7:07P</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>Jan. 13, 1998</b>
4. SOCIAL SECURITY NUMBER <b>308-32-3295</b>	5a. AGE—Last Birthday (Years) <b>66</b>	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo, Day, Yr) <b>March 4, 1931</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Ind.</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1953</b>		8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>Broadway Methodist</b>		9c. CITY, TOWN OR LOCATION OF DEATH <b>Merrillville</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Betty Sowder</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Truck Driver</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Transportation</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Jasper</b>	13c. CITY, TOWN OR LOCATION <b>DeMotte</b>	13d. STREET AND NUMBER <b>9042 W. Pheasant Tr.</b>	
13a. ZIP CODE <b>46310</b>	13i. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>white</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <b>12</b> College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) <b>Albert Weiler</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Viola Phillips</b>		20a. INFORMANT'S NAME (Type/Print) <b>Betty Weiler</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9042 W. Pheasant Tr., DeMotte, Ind. 46310</b>		20c. Relationship <b>wife</b>		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>Jan. 17, 1998 Salem Cemetery</b>		21c. LOCATION—City or Town, State <b>Hebron, Ind.</b>
22a. EMBALMER'S NAME <b>Julie A. Hay</b>		22b. EMBALMER'S LICENSE NO. <b>FD29600027</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Julie A. Hay</i>		24b. LICENSE NUMBER (of Licensee) <b>FD29600027</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Jackson Funeral Service FH89000009 PO Box 681, DeMotte, Ind. 46310</b>	
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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <b>Hypertension</b>			Approximate Interval Between Onset and Death <b>3 days</b>	
b. <b>Spasms</b>			<b>3 days</b>	
c. <b>Arteriovascular disease</b>			<b>5 years</b>	
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)		28. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN 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.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel B. Furman, MD</i>		29c. MEDICAL LICENSE NO. <b>01041202</b>
29d. DATE SIGNED (Month, Day, Year) <b>1/20/98</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Daniel B. Furman, MD, 8845 BROADWAY, MERRILLVILLE, IN 46410</b>		
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>		32. DATE FILED (Month, Day, Year) <b>February 26, 1998</b>		
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		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.		
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>JAN 22 1998 001402</b>		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		34i. _____		



FILED

JAN 18 1998

SAM ORRACH  
INDIAN LAKE COUNTY