STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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AFFIDAVIT FROM A KNOWLEDGEABLE PARTY

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
CROWN POINT, IN 46307

Crown Point, Indiana

STATE OF INDIANA, COUNTY OF LAKE, ss:

Cathy Svitek, being first duly sworn, on oath states that she is of lawful age and resides in the County of LAKE, State of Indiana. That she was the surviving ~~spouse~~ daughter of Lucille McLaughlin who died on the 7th day of June, 19 93, and that as such surviving spouse is the owner of the following real estate situated in LAKE County, Indiana:

Lot 52, Forsyth Highlands 4th Addition, in the City of Hammond as shown in Plat 28, page 53, Lake County, Indiana.

That said were husband and wife at the time they took title to the above described real estate and that they remained such continuously until the death of said decedent.

Cathy Svitek Personely and/as Executrix of William McLaughlin
Cathy Svitek

Sworn to before me and subscribed in my presence this 2nd day of September, 19 98.

Resident of Porter County.

Geri L Shelby
Notary Public

My Commission Expires: 11/11/99

JLY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.

SEP 4 1998

PREPARED BY: Cathy Svitek

SAM ORLICH
AUDITOR LAKE COUNTY

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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1591-93 **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

1. DECEASED—NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
Lucille McLaughlin	Female	11:25 A.	June 7, 1993

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)
274-18-8829	73			April 13, 1920	Belfoutain, Ohio

8a. WAS DECEDENT A US VETERAN?	8b. YEAR LAST SERVED IN US ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
NO	N/A	HOSPITAL: ☐ 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
Munster Community Hospital	Munster	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	William McLaughlin	Homemaker	Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hammond	6809 Leland Avenue

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+)
46323	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First Middle Last)	19. MOTHER'S NAME (First Middle Maiden Surname)
Irwin Hullinger	Edith Roberts

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
Mr. William McLaughlin	6809 Leland AVe., Hammond, IN 46323	Husband

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)	Calumet Park Cemetery June 11, 1993	Merrillville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Charles D. Scheuer, Jr.	1006049	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Charles D. Scheuer Jr (signature)	1006049	VIRGIL HUBER Funeral Home-3002869 7051 Kennedy, Hammond, IN 46323

THIS CERTIFIES THAT THE ... COMPLETE ... DEATH ON FILE WITH THE LAKE COUNTY HEALTH ...

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

JUN 22 1993

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Vascular collapse — Unknown

DUE TO (OR AS A CONSEQUENCE OF)

b. Due to arteriosclerotic heart and vascular disease

DUE TO (OR AS A CONSEQUENCE OF)

c.

DUE TO (OR AS A CONSEQUENCE OF)

d.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last.

(signature), MD
LAKE COUNTY HEALTH COMMISSIONER

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month Day Year)
Daniel D. Thomas MD (signature)	16120	June 21, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER SIGNATURE	32. DATE FILED (Month Day Year)
Alejandro Williams MD (signature)	June 22, 1993

CORONER USE ONLY

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.
June 7, 1993	

SDH06 004 State Form 10110 (R3 / 3-92) DEATHCER PD

TENTION ESTATE: Disclosure of the ... we need to pursue our responsibilities ... pluntary and there will be no penalty for ... sal.

cal No. 744

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Sept. 26, 1997 — Franklin Bermuda M.D.
Date Issued — Hammond Health Commissioner

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1. DECEASED-NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
William Herbert McLaughlin Jr.	Male	5:30AM	September 25, 1997

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)
271-12-4031	80			Jul 18, 1917	Bellefontaine, OH

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	N/A	HOSPITAL ☐ 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
6809 Leland	Hammond	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
Widowed	NONE	Regional Super. Bridge Driv.	Railroad

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Hammond	6809 Leland

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	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+)
46323	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	12	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
William McLaughlin Sr.	Hazel Watkins

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Cathy Svitek	1518 - 174th Place, Hammond, IN 46324	Daughter

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION - City or Town State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Sep 27, 1997 Calumet Park Cemetery	Merrillville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James W. Gholston	1004194	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Jakob Huber	1045362	3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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. METASTATIC ANDIFF. CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF) b.	
Conditions if any which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) c.	
	DUE TO (OR AS A CONSEQUENCE OF) 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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
MYCOSIS FUNGOIDES	No	No	No

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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
	102746A	9/26/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
George T. Asteris M.D., 2450 - 169th Street, Hammond, IN 46323

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
Franklin F. Bermuda M.D.	September 26, 1997

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			No	

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.
	No

SDH08-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

3