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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

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Chicago Title Insurance Company \*

499699 LD

MORRIS W. CARTER  
RECORDER

SAME NAME AFFIDAVIT

This is to certify that Francis Knight

<sup>is</sup> ~~an~~ one and the same person as Francis W. Knight who  
~~holds~~ <sup>holds</sup> title to the real estate described in Exhibit A attached  
<sup>holds a life estate</sup>

hereto.

Affiant further sayeth not.

Signature Robert G. Wright  
Printed name Robert G. Wright

Document is FILED  
NOT OFFICIAL!

APR 07 1999

PETER BENJAMIN  
LAKE COUNTY AUDITOR

State of Indiana

SS:

County of Lake

Before me, the undersigned, a Notary Public, personally  
appeared the affiant, and, being duly sworn by me upon oath, says  
that the facts alleged in the foregoing instrument are true.  
Signed, sealed, and delivered this 3rd day of March, 1999.

Signature Kathy L. Sebben

Printed Kathy L. Sebben

My County of Residence Lake

My Commission expires: \_\_\_\_\_

Kathy L. Sebben  
Notary Public, State of Indiana  
Lake County  
My Commission Exp. 09/14/2000

This affidavit was prepared by Robert G. Wright

000539

1300  
St  
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\* 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.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

Local No. 0212-98

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

202114  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

|   |  |  |                                  |   |  |  |   |
|---|--|--|----------------------------------|---|--|--|---|
| 1. DECEASED—NAME (First, Middle, Last)<br><b>Francis Wright</b>   |  |  |                                  | 2. SEX<br><b>Male</b>   | 3a. TIME OF DEATH<br><b>4:00PM</b>                     | 3b. DATE OF DEATH (Month, Day, Yr)<br><b>January 30, 1998</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>483-07-7106</b>   |  | 5a. AGE—Last Birthday (Years)<br><b>76</b>   | 5b. UNDER 1 YEAR<br>Months: Days | 5c. UNDER 1 DAY<br>Hours: Minutes   | 6. DATE OF BIRTH (Mo, Day, Yr)<br><b>Mar. 18, 1921</b> |  | 7. BIRTHPLACE (City and State or Foreign Country)<br><b>Centerville, Iowa</b> |
| 8a. WAS DECEDENT A U.S. VETERAN?<br><b>Yes WWII</b>   |  | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?<br><b>1943</b>  |                                  | 9a. PLACE OF DEATH (Check only one. See instructions.)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence |  |  |   |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>Munster Med-Inn</b>  |  |  |                                  | 9c. CITY, TOWN, OR LOCATION OF DEATH<br><b>Munster</b>  |  | 9d. COUNTY OF DEATH<br><b>Lake</b>   |   |
| 10. MARITAL STATUS (Specify)<br><b>Never Married</b>  |  | 11. SURVIVING SPOUSE (If wife, give maiden name)<br><b>none</b>  |                                  | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br><b>Rougher Helper</b>  |  | 12b. KIND OF BUSINESS/INDUSTRY<br><b>L.T.V. Steel</b>  |   |
| 13a. RESIDENCE—STATE<br><b>Indiana</b>  |  | 13b. COUNTY<br><b>Lake</b>   |                                  | 13c. CITY, TOWN, OR LOCATION<br><b>East Chicago</b>   |  | 13d. STREET AND NUMBER<br><b>4845 Baring Avenue</b>  |   |
| 13e. ZIP CODE<br><b>46312</b>   |  | 13f. INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes   |                                  | 14. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes |   |
| 16. FATHER'S NAME (First, Middle, Last)<br><b>Keith Wright</b>  |  | 17. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Merle Brown</b>  |                                  | 18. RACE—American Indian, Black, White, etc. (Specify)<br><b>white</b>  |  | 17. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>8</b>                             |   |
| 20a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Robert G. Wright</b>   |  |  |                                  | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3418 Franklin Highland, IN 46322</b>  |  | 20c. Relationship<br><b>Brother</b>  |   |
| 21a. METHOD OF DISPOSITION<br><input checked="" 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)<br><b>February 3, 1998<br/>Chapel Lawn Memorial Gardens</b> |                                  | 21c. LOCATION—City or Town, State<br><b>Schererville, Indiana</b>   |  |  |   |
| 22a. EMBALMER'S NAME<br><b>C. William McCoy</b>   |  | 22b. EMBALMER'S LICENSE NO.<br><b>FD01013612</b>   |                                  | 23. WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes   |  |  |   |
| 24. SIGNATURE OF FUNERAL DIRECTOR<br><i>[Signature]</i>   |  | 24b. LICENSE NUMBER (of Licensee)<br><b>FD01013507</b>   |                                  | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br><b>Bocken Funeral Home, Inc. FH83002801<br/>7042 Kennedy Ave., Hammond, IN 46323</b>   |  |  |   |
| 26. DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.   |  |  |                                  |   |  |  |   |
| 26. CAUSE OF DEATH (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)<br><b>FEB 03 1998</b>   |  | a. <b>congestive heart failure</b>   |                                  | b. <b>arteriosclerotic heart disease</b>  |  | APR 07 1999  |   |
| Conditions, if any, which gave rise to the immediate cause of death (Specify)<br><b>Diabetes Mellitus, Insulin Dependent, Hypertension, Recent Myocardial Infarction</b>  |  |  |                                  |   |  |  |   |
| 26. CAUSE OF DEATH (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.)<br><b>PETER BENJAMIN LAKE COUNTY AUDITOR</b>  |  |  |                                  |   |  |  |   |
| PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I<br><b>Diabetes Mellitus, Insulin Dependent, Hypertension, Recent Myocardial Infarction</b>   |  |  |                                  | 27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)<br><b>No</b>   |  | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no)<br><b>No</b>  |   |
| 29a. CERTIFIER (Check only one)<br><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<br><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<br><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<br><i>[Signature]</i>  |                                  | 29c. MEDICAL LICENSE NO.<br><b>IN 20248</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>2/2/98</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br><b>W V HETEMANN, MD 7905 CALVERT AVE MUNSTER, IN 46321</b>  |  |  |                                  |   |  |  |   |
| 31. HEALTH OFFICER'S SIGNATURE<br><i>[Signature]</i> DATE FILED (Month, Day, Year)<br><b>February 3, 1998</b>   |  |  |                                  |   |  |  |   |
| 33. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide  |  | 34a. DATE OF INJURY (Month, Day, Year)   |                                  | 34b. TIME OF INJURY   |  | 34c. INJURY AT WORK? (Yes or no)   |   |
|   |  | 34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)  |                                  | 34d. DESCRIBE HOW INJURY OCCURRED<br><b>000540</b>  |  |  |   |
| 34g. DATE PRONOUNCED DEAD (Month, Day, Year)  |  |  |                                  | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.   |  |  |   |

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

2

EXHIBIT "A"

LOT 42 AND THE NORTH 1/2 OF LOT 41, BLOCK 20, SUBDIVISION OF THE EAST 4/7THS OF THE SOUTHWEST QUARTER OF SECTION 29, TOWNSHIP 37 NORTH, RANGE 9 WEST OF THE 2ND PRINCIPAL MERIDIAN, IN THE CITY OF EAST CHICAGO, AS SHOWN IN PLAT BOOK 2, PAGE 15, IN LAKE COUNTY, INDIANA.

