



COMMUNITY TITLE COMPANY

- An Indiana Corporation
421 West 81st Avenue
Merrillville, Indiana 46410

99083511

219-736-2810

OCT -8 AM 10:49

AFFIDAVIT MORRIS W. CARTER
RECORDER

FILED

OCT 04 1999

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

**PETER BENJAMIN
LAKE COUNTY AUDITOR**

JACK W. CULVER, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, DOROTHY CULVER died (without leaving a will) (~~XXXXXXXXXX~~) on APRIL 16 19 99 at MARY E. BARTZ HOSPICE CENTER

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 111 IN CRESCENT LAKE UNIT #2, IN THE TOWN OF MERRILLVILLE, AS PER PLAT THEREOF, RECORDED DECEMBER 11, 1979 IN PLAT BOOK 51 PAGE 77, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

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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) (her) 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.

COMMUNITY TITLE COMPANY

FILE NO 218417 SCH

Further affiant sayeth not.

Jack W. Culver
JACK W. CULVER

Subscribed and sworn to before me, a Notary Public, this 29th day of SEPTEMBER, 1999.

Karen Gatons
Notary Public

My Commission expires:

County of Residence:

KAREN GATONS
Notary Public, State of Indiana
County of Lake
My Commission Expires 11/04/2006

000207

This Instrument prepared by Patrick J. McManama
ID No. 9534-45

Comme
10/14
12:00

This Document Not Valid Unless
Stamped on Reverse Side and
Embossed with Raised Seal of
Porter County

PORTER COUNTY
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) DOROTHY CULVER		2. SEX FEMALE	3a. TIME OF DEATH 9:50 PM	3b. DATE OF DEATH (Month, Day, Yr.) APRIL 16, 1999	
4. SOCIAL SECURITY NUMBER 306-28-2291	5a. AGE - Last Birthday (Years) 72	5b. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____	6. DATE OF BIRTH (Mo., Day, Yr.) DEC. 7, 1926	7. BIRTHPLACE (City and State or Foreign Country) INDIANA HARBOR, IN
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) MARY E. BARTZ HOSPICE CENTER		9c. CITY, TOWN, OR LOCATION OF DEATH VALPARAISO		9d. COUNTY OF DEATH PORTER	
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) JACK CULVER	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) RETAIL SALES		12b. KIND OF BUSINESS/INDUSTRY CARSON, PIRIE, SCOTT	
13a. RESIDENCE - STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION MERRILLVILLE	13d. STREET AND NUMBER 7476 MORTON		
13e. ZIP CODE 46410	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? (Specify) <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) 12 College (1-4 or 5+)
18. FATHER'S NAME (First, Middle, Last) MARION KOLEFF		19. MOTHER'S NAME (First, Middle, Maiden Surname) LYDIA TROUTMAN			
20a. INFORMANT'S NAME (Type/Print) JACK CULVER		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7476 MORTON, MERRILLVILLE, IN 46410		20c. Relationship HUSBAND	
21a. METHOD OF DISPOSITION <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) APRIL 20, 1999 ELMWOOD CEMETERY		21c. LOCATION - City or Town, State HAMMOND INDIANA	
22a. EMBALMER'S NAME RUSSELL KRAFT, JR.		22b. EMBALMER'S LICENSE NO. 29300105		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) 1009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME, 10101 BROADWAY CROWN POINT, INDIANA 46307-8801	
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. Metastatic Cancer of Pancreas		FDH83002445		Approximate Interval Between Onset and Death 5 months	
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. _____ DUE TO (OR AS A CONSEQUENCE OF): b. _____ 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? (Y, N or U) NO		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/I	
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 in 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) as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Mirro</i>		29c. MEDICAL LICENSE NO. 24382	
29d. DATE SIGNED (Month, Day, Year) 4/21/99		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/Print) DR. MIRRO, 8895 BROADWAY, MERRILLVILLE, INDIANA			
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Babcock MD</i>		32. DATE FILED (Month, Day, Year) April 22, 1999			
33. MANNER OF DEATH <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)		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.					