9

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99084038

99 OCT 12 AM 10:55

MORRIS W. CARTER
RECORDER

FILED

OCT 08 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Elnora Breidenbaugh, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Cletus J. Breidenbaugh died (without leaving a will) (~~leaving a will~~) on July 8, 1991 at ST. MARGARET HOSPITAL, HAMMOND, IND.

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

The South 2.5 feet of lot 22 and all of lot 23 in Block 2 in Ford-Roxana Addition to Hammond, as per plat thereof, DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER. August 2, 1926 in Plat Book 20, Page 23, in the Office of the Recorder of Lake County, Indiana.

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PETER BENJAMIN
LAKE COUNTY AUDITOR

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.

Further affiant sayeth not.

COMMUNITY TITLE COMPANY
FILE NO L 18502 GH

Elnora Breidenbaugh

Subscribed and sworn to before me, a Notary Public, this 24th day of September, 1999.

Helen L Rutherford
Notary Public

Notary Public, Cobb County, Georgia
My Commission Expires July 9, 2000

11.00
E.P.

Comp
#1083

This instrument prepared by:
Patrick J. McManama
Attorney ID#9534-45

000629

25 X

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

July 9, 1991 Date Issued — Franklin D. Pemudo M.D. Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

No. 529

1 DECEASED—NAME (First, Middle, Last): CLETUS BREIDENBAUGH	2 SEX: Male	3a TIME OF DEATH: 8:10PM	3b DATE OF DEATH (Month, Day, Yr.): July 8, 1991		
4 SOCIAL SECURITY NUMBER: 304-07-4683	5a AGE—Last Birthday (Years): 82	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo., Day, Yr.): February 18, 1909	7 BIRTHPLACE (City and State or Foreign Country): Portersville, Indiana
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? ----	8c PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient; ☐ ER/Outpatient; ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify); ☐ Residence		
9a FACILITY NAME (If not institution, give street and number): St. Margaret Hospital	9b CITY, TOWN OR LOCATION OF DEATH: Hammond	9c COUNTY OF DEATH: Lake			
10 MARITAL STATUS (Specify): Married	11 SURVIVING SPOUSE (If wife, give maiden name): Elnora Bauer	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright	12b KIND OF BUSINESS/INDUSTRY: L.T.V. Steel		
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Hammond	13d STREET AND NUMBER: 7350 Jarnecke Ave.		
13e ZIP CODE: 46324	13f INSIDE CITY LIMITS? ☐ No XX Yes	13g ON A FARM? XX No ☐ Yes	14 CITIZEN OF WHAT COUNTRY: U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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): 8 years; College (1-4 or 5+): ----					
18 FATHER'S NAME (First, Middle, Last): Edward J. Breidenbaugh	19 MOTHER'S NAME (First, Middle, Maiden Surname): Flora Mehnde MEHNE				
20a INFORMANT'S NAME (Type/Print): Elnora Breidenbaugh	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7350 Jarnecke Ave. Hammond, Indiana 46324	20c Relationship: Wife			
21a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 12, 1991 Chapel Lawn Memorial Gardens	21c LOCATION—City or Town, State: Schererville, Indiana			
22a EMBALMER'S NAME: Charles W. Wells	22b EMBALMER'S LICENSE NO: #1042372	23 WAS DEATH REPORTED TO CORONER? XX No ☐ Yes			
24a SIGNATURE OF FUNERAL DIRECTOR: Anthony Solan	24b LICENSE NUMBER (of Licensee): FD# 1051840	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH# 3002893 7109 Calumet Ave., Hammond, Ind. 46324			

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. hepato-renal syndrome	3 days
	DUE TO (OR AS A CONSEQUENCE OF): b. staphylococcal Sepsis	10 days
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): c. neutropenia	5 years
	DUE TO (OR AS A CONSEQUENCE OF): d. myelodysplastic Syndrome	5 years

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: congestive heart failure

27 WAS DECEDENT PREGNANT ON 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	----

29a CERTIFIER (Check only one): XX 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)
	0103625-9	July 9, 1991

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): J.H. Gleaton M.D. 7905 Calumet Ave. Munster, Indiana 46321

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Pemudo M.D.	July 9, 1991

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.			

SBH08 004 State Form 10110 (R2/3-89) DEA CERT PD 1

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