STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99085401

TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

AFFIDAVIT

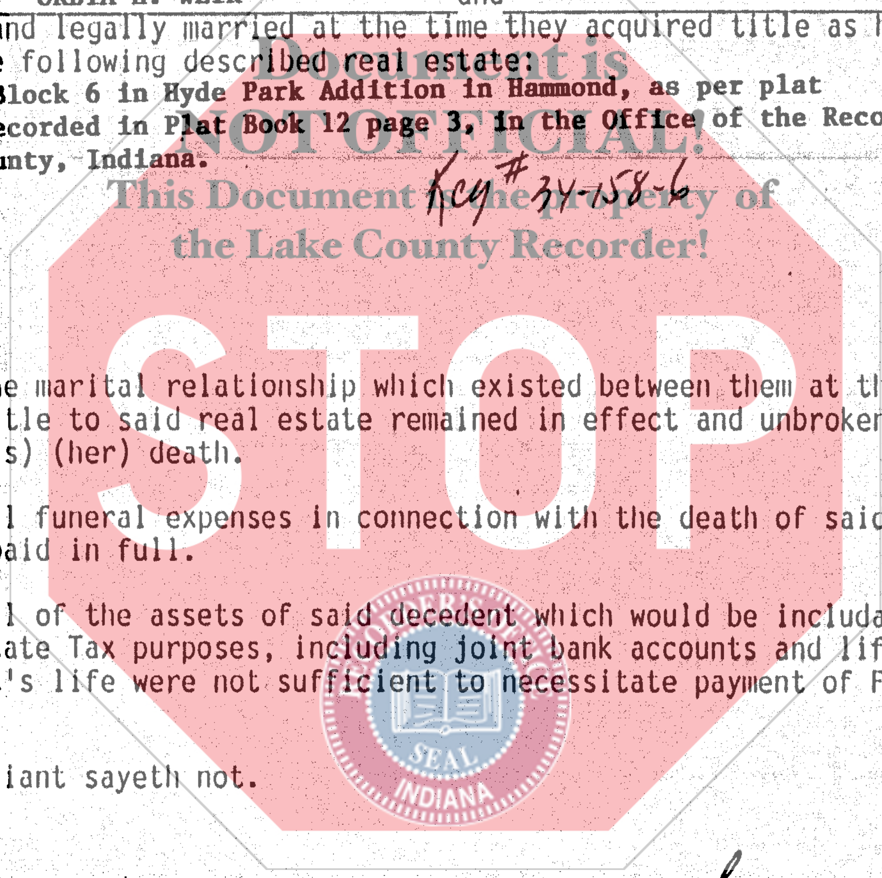
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STEPHEN R. WEIR, being first duly sworn upon oath, deposes and says:

1. That **ORBIA H. WEIR** died on **January 14**, 19**88** at **HAMMOND, IN**.

2. That **ORBIA H. WEIR** and **MARION D. WEIR** were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
Lot 6 in Block 6 in Hyde Park Addition in Hammond, as per plat thereof, recorded in Plat Book 12 page 3, in the Office of the Recorder of Lake County, Indiana.

Key # 34-158-6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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.

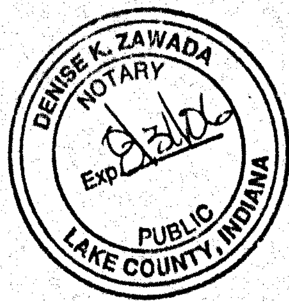
4. That all funeral expenses in connection with the death of said decedent have been paid in full.

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.

Further affiant sayeth not.

STEPHEN R. WEIR

Subscribed and sworn to before me, a Notary Public, this **09th** day of **September**, 19 **99**.



DENISE K. ZAWADA Notary Public

My Commission expires:
8-31-2006

County of Residence:
Lake

This Instrument prepared by **STEPHEN R. WEIR**

11.00 E.P. Ti

99206036
SD

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

JAN 1 9 1988 [signature] M.D.

Date Issued — Hammond Health Commissioner

Local No. 51 — State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME First: Orbia Middle: H Last: Weir
2. SEX: Male
3. DATE OF DEATH (Mo. Day, Yr.): January 14, 1988
4. SOCIAL SECURITY NUMBER: 557-34-0696
5a. AGE—Last Birthday (Years): 63
5b. UNDER 1 YEAR Months Days
5c. UNDER 1 DAY Hours Minutes
6. DATE OF BIRTH (Month Day, Year): June 29, 192
7. BIRTHPLACE (City and State or Foreign Country): Norphet, Arkansas
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: not known
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 6420 Van Buren Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marion Greer
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Driver (truck)
12b. KIND OF BUSINESS/INDUSTRY: L.T.V. Steel Corp.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 6420 VanBuren St.
13e. INSIDE CITY LIMITS? (Yes or no): Yes
13f. FARM: No
13g. ZIP CODE: 46324
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): N.A. College (1-4 or 5+)

PARENTS

17. FATHER'S NAME (First, Middle, Last): Orv Weir
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertie Utley

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Marion Weir
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6420 VanBuren, Hammond, IN 46324
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Evergreen Memorial Park January 18, 1988
20c. LOCATION—City or Town, State: Hobart, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b. LICENSE NUMBER (of Licensee): FDE1018769
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: C.J.Huber Funeral Home, 722-165th, Hammond, IN 46324 FDH: 3002851

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH: 5:48 P. M
25. DATE PRONOUNCED DEAD (Month, Day, Year): January 14, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): Yes

CAUSE OF DEATH (SEE INSTRUCTIONS)

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Ruptured abdominal aortic aneurysm — Approximate Interval Between Onset and Death: Unknown
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

CERTIFIER (SEE INSTRUCTIONS)

29a. CERTIFIER (Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☒ CORONER ☐ 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) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 16120
29d. DATE SIGNED (Month, Day, Year): January 19, 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32. DATE FILED (Month, Day, Year): JAN 19, 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homocide
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)

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