

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD



99085786

99 OCT 19 AM 9:07

TICOR TITLE INSURANCE

MONSIEUR W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

RICHARD T. CONCIALDI, JR., being first duly sworn upon oath, deposes and says:

1. That NATALIE CONCIALDI died on FEBRUARY 07, 19 95 at LAKE COUNTY, INDIANA.
2. That RICHARD T. CONCIALDI, JR. and NATALIE CONCIALDI were duly and legally married at the time they acquired title as husband and wife to the following described real estate: LOT 13 IN BLOCK 10 WOODLAWN ADDITION TO GRIFFITH, AS PER PLAT THEREOF RECORDED IN PLAT BOOK 21 PAGE 15, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

This Document is the property of the Lake County Recorder! *Key # 26-145-13*

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 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.

Richard T. Concialdi, Jr.
RICHARD T. CONCIALDI, JR.

Subscribed and sworn to before me, a Notary Public, this 14TH day of OCTOBER, 19 99.

FILED

Thomas G. Schiller
Notary Public
THOMAS G. SCHILLER

My Commission expires: OCT 18 1999
6-7-00

County of Residence: LAKE
**PETER BENJAMIN
LAKE COUNTY AUDITOR**

001105

This Instrument prepared by RICHARD T. CONCIALDI, JR.

11.00 E.P. TC

TICOR TITLE INSURANCE #99108987
Highland, Indiana
LEROY

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0296-95

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

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

TICOR TITLE INSURANCE #99089 BT LEROY 1037 19 6806

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Natalie Concialdi		2 SEX Female	3a TIME OF DEATH 2:50 AM	3b DATE OF DEATH (Month Day Year) February 7, 1995	
4 *SOCIAL SECURITY NUMBER 305-82-6687	5a AGE—Last Birthday (Year) 32	5b UNDER 1 YEAR Months Days Hours 0 0 0	5c UNDER 1 DAY : 6 DATE OF BIRTH (Mo. Day Yr) Aug. 9, 1962	7 BIRTHPLACE (City and State or Foreign Country) Martinez, California	
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) Regency Place Nursing Home		9c CITY TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Richard Concialdi	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker	12b KIND OF BUSINESS/INDUSTRY Own Home		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Griffith	13d STREET AND NUMBER 201 N. Woodlawn		
13e ZIP CODE 46319	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? <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) College (1-4 or 5-) 12		18 FATHER'S NAME (First Middle Last) Joe Hamilton			
19 MOTHER'S NAME (First Middle Maiden Surname) Alice Rodriguez		20a INFORMANT'S NAME (Type/Print) Richard Concialdi			
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 201 N. Woodlawn Griffith, Indiana		20c Relationship Husband			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) February 10, 1995 Memory Lane Cemetery		21c LOCATION—City or Town State Schererville, Indiana		
22a EMBALMER'S NAME David Peterson		22b EMBALMER'S LICENSE NO FDO 8601585	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd Highland, Indiana FH83007500		
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. Cerebral anoxia		26b CERTIFIED THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. OCT 05 1999			
26c IMMEDIATE CAUSE (Final disease or condition resulting in death)		26d DUE TO (OR AS A CONSEQUENCE OF)			
26e Conditions if any which gave rise to the immediate cause, stating the underlying cause last		26f DUE TO (OR AS A CONSEQUENCE OF)			
26g DUE TO (OR AS A CONSEQUENCE OF)		26h DUE TO (OR AS A CONSEQUENCE OF)			
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) NO	28a WAS AN AUTOPSY PERFORMED BY HEALTH OFFICER? (Yes or no) NO	28b WERE AUTOPSY FINDINGS COMPLETED TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
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 to 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) and manner as stated.		29b SIGNATURE AND TITLE OF CERTIFIER <i>A. Stamer</i>			
29c MEDICAL LICENSE NO 01025591		29d DATE SIGNED (Month Day Year) 2-8-95			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Alexander Stamer 6100 N. 11th Street Munster IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Stamer, M.D.</i>			32 DATE FILED (Month Day Year) February 8, 1995		
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.			

FILED
OCT 18 1999