STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99087008 99 OCT 22 AM 9:06

MICHAEL W. CARTER
RECORDER

TICOR TITLE INSURANCE

FILED

OCT 21 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

DIANE L. SHAPLEY, being first duly sworn upon oath, deposes and says:

1. That ROBERT C. SHAPLEY died on APRIL 30, 19 92 at ST. VINCENT HOSPITAL.

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

LOT 7 IN BLOCK 3 IN ENGLEHART'S COUNTRY CLUB MANOR SECOND ADDITION, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 34, PAGE 13 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Key 15-347-7

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.

Diane L. Shapley
DIANE L. SHAPLEY

Subscribed and sworn to before me, a Notary Public, this 18th day of October, 19 99.

DENISE K. ZAWADA NOTARY PUBLIC LAKE COUNTY, INDIANA Exp. 8/31/06

Denise K. Zawada
DENISE K. ZAWADA Notary Public

My Commission expires:
8/31/06

County of Residence:
LAKE

001380

11.00 E.P.

This Instrument prepared by DIANE L. SHAPLEY

Ticor Sch
99112 IBT.

T Cor Scr
911218.1 - Talley,

OFFICIAL COPY
MARION COUNTY HEALTH DEPARTMENT
3838 NORTH RURAL ST.
INDIANAPOLIS, INDIANA 26205
CERTIFICATE OF DEATH

L08861 H1002160
PLEY, ROBERT C
-CARDIOLOGY
State No. .....

I No. .....

NOT VALID UNLESS MACHINE NUMBERED AND SIGNED WITH MULTICOLOR RIBBON ON THE REVERSE SIDE

PE/PRINT IN RMANENT LACK INK 12cc

ECEDENT

ARENTS

NFORMANT

ISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last): ROBERT C. SHAPLEY		2. SEX: Male	3a. TIME OF DEATH: 7:00 PM	3b. DATE OF DEATH (Month, Day, Yr): 04-30-92	April 30 1992
4. SOCIAL SECURITY NUMBER: 312-42-5453	5a. AGE—Last Birthday (Years): 47	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr): 05-17-44	7. BIRTHPLACE (City and State or Foreign Country): GARY, INDIANA
8a. WAS DECEDENT A US VETERAN? NO	8b. YEAR LAST SERVED IN US ARMED FORCES? N/A	9a. PLACE OF DEATH (Check only one. See Instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence		
9b. FACILITY NAME (If not institution, give street and number): ST. VINCENT HOSPITAL 2001 W. 86TH ST.		9c. CITY, TOWN, OR LOCATION OF DEATH: INDIANAPOLIS	9d. COUNTY OF DEATH: MARION		
10. MARITAL STATUS (Specify): MARRIED	11. SURVIVING SPOUSE (If wife give maiden name): DIANA SHAPLEY ZIMNY	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): INSURANCE ADJUSTER	12b. KIND OF BUSINESS/INDUSTRY: Insurance		
13a. RESIDENCE—STATE: IN	13b. COUNTY: LAKE	13c. CITY, TOWN, OR LOCATION: GARY	13d. STREET AND NUMBER: 1335 N. 62ND AVENUE		
13e. ZIP CODE: 46410	13f. INSIDE CITY LIMITS: ☐ No ☑ Yes	13g. ON A FARM? ☑ No ☐ Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12	College (1-4 or 5+): 1				
18. FATHER'S NAME (First, Middle, Last): FRANCIS E. SHAPLEY		19. MOTHER'S NAME (First, Middle, Maiden Surname): MARCELLA WEHNER			
20a. INFORMANT'S NAME (Type/Print): DIANA SHAPLEY	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1335 WEST 62ND AV. GARY, IN. 46410	20c. Relationship: WIFE (~~ST JUDGE~~)			
21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MAY 4, 1992 CALUMET PARK	21c. LOCATION—City or Town, State: MERRILLVILLE, IN.			
22a. EMBALMER'S NAME: MICHAEL D. GERBER	22b. EMBALMER'S LICENSE NO: 860501	23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR: Michael D. Gerber	24b. LICENSE NUMBER (of Licensee): 860501	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: GERBER FUNERAL HOME #3007762 7905 BROADWAY, MERRILLVILLE, IN.			

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. ACUTE AORTIC DISSECTION (TYPE I)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. 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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

29a. CERTIFIER (Check only one)
☒ 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)
John M. Davis MD	027134	APRIL 30, 1992

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Frank Thomas MD	MAY 4 1992

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			