STATE OF INDIANA
COUNTY
RD
2000 014152
3:49
ER

# AFFIDAVIT

STATE OF INDIANA)
)
COUNTY OF LAKE )

CHARLES M. GOURLAY BEING FIRST DULY SWORN

UPON HIS OATH, DEPOSES AND SAYS:

THAT JOSEPHINE B. GOURLAY DIED ON THE Aug

DAY OF 20, 19 99 AT 3:50 AM.

THAT AT THE TIME OF HER DEATH, SHE WAS A CO-OWNER AS A JOINT

TENANT WITH CHARLES M. GOURLAY AND CATHERINE A. MORGAN

OF THE FOLLOWING DESCRIBED REAL ESTATE:

(SEE ATTACHED EXHIBIT "A")

COMMONLY KNOWN AS 806 LINCOLN ST., HOBART, IN. 46342
UNIT 27 KEY NO. 17-31-13

THAT NO FEDERAL ESTATE TAX OR INDIANA INHERITANCE TAX IS DUE AS A

RESULT OF THE DEATH OF JOSEPHINE B. GOURLAY.

THAT THIS AFFIANT'S RELATIONSHIP TO THE DECEDENT WAS SON.

FURTHER AFFIANT SAITH NOT.

Charles M Gourlay
CHARLES M. GOURLAY

BEFORE ME THE UNDERSIGNED NOTARY PUBLIC IN AND FOR SAID COUNTY AND STATE, THIS 25th DAY OF February, ~~19~~ 2000, PERSONALLY APPEARED CHARLES M. GOURLAY AND ACKNOWLEDGED THE EXECUTION OF THE ABOVE DOCUMENT.

Tracie A. Kraszyk
Tracie A. Kraszyk NOTARY PUBLIC

MY COMMISSION EXPIRES:
01-12-08

COUNTY OF RESIDENCE: Porter

THIS INSTRUMENT PREPARED BY: PATRICK McMANAMA, ATTORNEY AT LAW ID 9534-45

COMMUNITY TITLE COMPANY
FILE NO 19118

FILED

FEB 29 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

Comm
1337

61805

EXHIBIT "A"

PART OF THE NORTHEAST 1/4 OF THE NORTHEAST 1/4 OF THE NORWEST 1/4 OF THE SOUTHEAST 1/4 OF THE SOUTHWEST 1/4 OF SECTION 32, TOWNSHIP 36 NORTH, RANGE 7, WEST OF THE SECOND PRINCIPAL MERIDIAN, DESCRIBED AS COMMENCING AT A POINT 33 FEET WEST AND 83 FEET SOUTH OF THE NORTHEAST CORNER OF SAID TRACT AND RUNNING THENCE SOUTH 75 FEET TO THE NORTHEAST CORNER OF LOT 1 IN CHARLES M. BARNEY'S LINCOLN PARK ADDITION TO HOBART; THENCE WEST ALONG THE NORTH LINE OF SAID LOT 1, A DISTANCE OF 125 FEET; THENCE NORTH 75 FEET; THENCE EAST 125 FEET TO THE PLACE OF BEGINNING, IN THE CITY OF HOBART, LAKE COUNTY, INDIANA.

his document not valid unless
tamped on reverse side and
mbossed with raised seal of
orter County

# PORTER COUNTY CERTIFICATE OF DEATH

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): JOSEPHINE B. GOURLAY
2. SEX: Female
3a. TIME OF DEATH: 3:50AM
3b. DATE OF DEATH (Month Day Yr): August 20, 1999
4. SOCIAL SECURITY NUMBER: 305-28-6385
5a. AGE - Last Birthday (Years): 79
5b. UNDER 1 YEAR (Months Days):
5c. UNDER 1 DAY (Hours Minutes):
6. DATE OF BIRTH (Mo Day Yr): August 9, 1920
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): Valparaiso Care & Rehab. Ctr.
9c. CITY TOWN OR LOCATION OF DEATH: Valparaiso
9d. COUNTY OF DEATH: Porter
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Reporter/Typesetter
12b. KIND OF BUSINESS INDUSTRY: Communications
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Porter
13c. CITY TOWN OR LOCATION: Valparaiso
13d. STREET AND NUMBER: 606 Wall Street
13e. ZIP CODE: 46383
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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Howard Bracken
19. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Ressieg

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Margaret E. Heydrick
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6813 Sunnybrook Drive, Frederick, MD
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): August 23, 1999 Hobart Cemetery
21c. LOCATION - City or Town State: Hobart, Indiana
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FDO1006463
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

CAUSE OF DEATH

28. 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Bronchuclasis
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions if any which gave rise to the immediate cause stating the underlying cause last

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: ASCVD. Polymyalgia Rheumatica
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): 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): No

CERTIFIER

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: Joel Hull
29c. MEDICAL LICENSE NO: 01020457
29d. DATE SIGNED (Month Day Year): 8/23/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): Joel Hull MD, 650 Dickenson Road, Chesterton, IN 46304

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Mary A. Brinker MD
32. DATE FILED (Month Day Year): August 24, 1999

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