

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

FILED

STATE OF INDIANA

2000 015240

2000 MAR 3 AM 9:01

COUNTY OF LAKE

MORRIS W. CARTER RECORDER
MAR 01 2000

AFFIDAVIT

**PETER BENJAMIN
LAKE COUNTY AUDITOR**

MARY A. WONG, being first duly sworn upon her oath deposes and says:

1. That affiant's husband, SAMUEL N.T. WONG, died on June 22, 1998, at Munster, Indiana.
2. That she and her husband, SAMUEL N. T. WONG, were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

The North 100 acres of the Southwest 1/4 Section 18, Township 34 North, Range 7 West of the 2nd Principal Meridian, in Lake County, Indiana; except the West 20 feet thereof and except the South 208.75 feet of the East 208.75 feet thereof.

Key No.: 10-14-8

3. That the marital relationship which existed between affiant and her husband at the time they acquired title to said real estate remained in effect and unbroken until the date of her husband's death, and that by operation of law, she then became owner of the above described real estate in fee simple title absolute, free and clear of any Indiana transfer tax.
4. That all funeral expenses in connection with the death of affiant's husband have been paid in full.
5. That no Federal Estate Taxes became due as a result of the death of SAMUEL N. T. WONG.
6. Further affiant sayeth not.



MARY A. WONG

SUBSCRIBED AND SWORN to before me, a Notary Public in and for said County and State, this 15th day of February, 2000.

My Commission Expires: 3/02/00
Resident of Lake County, Indiana

Samuel T. Miller
SAMUEL T. MILLER, Notary Public

Prepared by SAMUEL T. MILLER, Attorney #9837-45
9335 Calumet Avenue, Munster, IN 46321

00363

72.00
1662

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

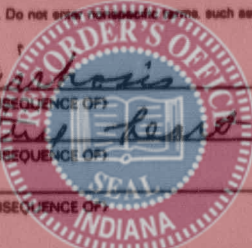
State No.

Local No. 1446-98

260337
TYPE/PRINT
IN
PERMANENT
BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

1. DECEASED—NAME (First, Middle, Last) SAMUEL N.T.		2. SEX MALE		3a. TIME OF DEATH 11:00 P.M.		3b. DATE OF DEATH (Month, Day, Yr.) JUNE 22, 1998	
4. SOCIAL SECURITY NUMBER 337-30-7631		5a. AGE—Last Birthday (Years) 77		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr.) June 14, 1921		7. BIRTHPLACE (City and State or Foreign Country) China					
8a. WAS DECEASED A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? No		9a. PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL				9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Mary Lee		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Physician		12b. KIND OF BUSINESS/INDUSTRY Medical	
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Munster		13d. STREET AND NUMBER 1230 Tulip Lane	
13e. ZIP CODE 46321		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) Asian		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+			
18. FATHER'S NAME (First, Middle, Last) Peter Wong				19. MOTHER'S NAME (First, Middle, Last) Esther Tee			
20a. INFORMANT'S NAME (Type/Print) Mary Wong				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1230 Tulip Lane Munster, IN 46321		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) June 26, 1998 NW IN Crematory Services		21c. LOCATION—City or Town, State Crown Point, IN			
22a. EMBALMER'S NAME Brian T. Burns		22b. EMBALMER'S LICENSE NO. 8601763		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b. LICENSE NUMBER (of Licensee) 1045184		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home#3004968 8415 Calumet Munster, IN 46321			
26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter <u>obvious</u> 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) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. a. <i>liver cirrhosis</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____		27. WAS DECEASED 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) --	
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>Cancer of colon</i>							
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>[Signature]</i>		29c. MEDICAL LICENSE NO. 01031576		29d. DATE SIGNED (Month, Day, Year) JUNE 23 1998	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) WON-SHICK LOH, M.D. 9134 COLUMBIA AVENUE, MUNSTER, INDIANA 46321							
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>				32. DATE FILED (Month, Day, Year) <i>June 24, 1998</i>			
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. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. 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.					



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER