

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

**FILED**

STATE OF INDIANA

2000 015242

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:

Lot 11, Fairmeadow 17<sup>th</sup> Addition, Block Two, to the Town of Munster, as shown in Plat Book 43, Page 25, in Lake County, Indiana.

**This Document is the property of the Lake County Recorder!**

Key No. 27-496-23

Commonly known as 1230 Tulip Lane, Munster, Indiana.

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*  
\_\_\_\_\_  
MARY A. WONG

SUBSCRIBED AND SWORN to before me, a Notary Public in and for said County and State, this 15<sup>th</sup> 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

00361

12.00  
1661



\* 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. 1440-98

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) <b>SAMUEL N.T. WONG, M.D.</b>		2. SEX <b>MALE</b>		3a. TIME OF DEATH <b>11:00 P.M.</b>		3b. DATE OF DEATH (Month Day, Yr) <b>JUNE 22, 1998</b>	
4. SOCIAL SECURITY NUMBER <b>337-30-7631</b>		5a. AGE—Last Birthday (Years) <b>77</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo. Day, Yr) <b>June 14, 1921</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>China</b>					
8a. WAS DECEASED A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>No</b>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA 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) <b>THE COMMUNITY HOSPITAL</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>		9d. COUNTY OF DEATH <b>LAKE</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Mary Lee</b>		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Physician</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Medical</b>	
13a. RESIDENCE—STATE <b>IN</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Munster</b>		13d. STREET AND NUMBER <b>1230 Tulip Lane</b>	
13e. ZIP CODE <b>46321</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. WAS DECEASED OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) <b>Asian</b>		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>			
18. FATHER'S NAME (First Middle Last) <b>Peter Wong</b>				19. MOTHER'S NAME (First Middle Last) <b>Esther Zee</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Mary Wong</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1230 Tulip Lane Munster, IN 46321</b>				20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>June 26, 1998 NW IN Crematory Services Crown Point, IN</b>		21c. LOCATION—City or Town, State			
22a. EMBALMER'S NAME <b>Brian T. Burns</b>		22b. EMBALMER'S LICENSE NO. <b>8601763</b>		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) <b>1045184</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321</b>			
26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter non-causal 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. <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. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.		26. PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I. <i>Cancer of colon</i>		27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>---</b>		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>Alexander S. Williams MD</i>		29c. MEDICAL LICENSE NO. <b>01031576</b>	
29d. DATE SIGNED (Month Day, Year) <b>JUNE 23 1998</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>WON-SHICK LOH, M.D. 9134 COLUMBIA AVENUE, MUNSTER, INDIANA 46321</b>					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>		32. DATE FILED (Month Day, Year) <b>June 24, 1998</b>					
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.					

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER