STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 MAR 1? AM 9:07

MORRIS W. CARTER

2000 017394

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MABEL M. OSWALD, being first duly sworn upon oath, deposes and says:

1. That ALFRED J. OSWALD died on MARCH 16, 19 92 at SOUTHLAKE CARE CENTER.

2. That ALFRED J. OSWALD and MABEL M. OSWALD were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 1 IN BLOCK 4 IN SECOND ADDITON TO LIVERPOOL HOME GARDENS, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 25 PAGE 10, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

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Kt 48-37-1

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.

STOP
RECORDER'S OFFICE SEAL INDIANA

Mabel M Oswald
MABEL M. OSWALD

Subscribed and sworn to before me, a Notary Public, this 29TH day of FEBRUARY, 19 2000

Karen Kane
KAREN KANE Notary Public

FILED
MAR 1? 2000

My Commission expires: 09-12-07
RESIDING IN PORTER COUNTY

County of Residence:

PETER BENJAMIN
LAKE COUNTY AUDITOR

11.00

This Instrument prepared by MABEL M. OSWALD

99206714-CR
TICOR TITLE INSURANCE
Crown Point Indiana

?5913

Local No. 0631-92

9Reg
2 Vet
11 Total

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
ALFRED J. OSWALD	Male	4:00A.M.	March 16, 1992

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days)	5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
713-14-9979	76			AUG 27, 1915	KITZVILLE, MINNESOTA

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1945	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
SOUTHLAKE CARE CENTER	MERRILLVILLE	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	MABEL M. ADAMS	CRANE OPERATOR	US STEEL GARY WORKS

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	LAKE STATION	2868 ELKHART STREET

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46405	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	8	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
FRANK OSWALD	GERTRUDE SKERLINE

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
MABEL M. OSWALD	2868 ELKHART ST., LAKE STATION, IN 46405	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	MAR 18, 1992 RIDGELAWN CEMETERY	GARY, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
JAMES W. GHOLSTON	FDO1004194	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FDO1006463	FH83003069 REES FUNERAL HOMES INC 600 W. RIDGE RD, HOBART, IN 46342

CAUSE OF DEATH

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. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Senile Dementia
DUE TO (OR AS A CONSEQUENCE OF):
c. Spino cerebellar degenerative disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

THIS CERTIFICATE COMPLETE DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. MAR 18 1992

LAKE COUNTY HEALTH COMMISSIONER

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)
	N/A	No	N/A

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	01032180	3/18/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
SURENDRA J. SHAH MD, 3520 FAIRVIEW AVENUE, LAKE STATION, IN 46405

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander S. Williams, MD	March 18 1992

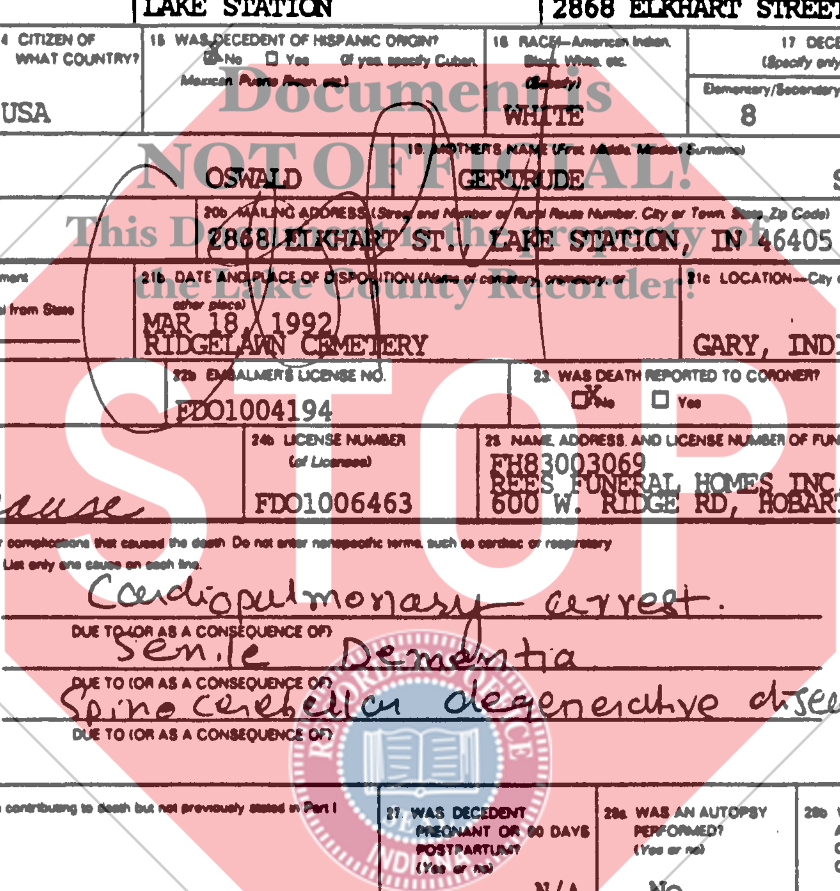
CORONER USE ONLY

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.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO 1



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