

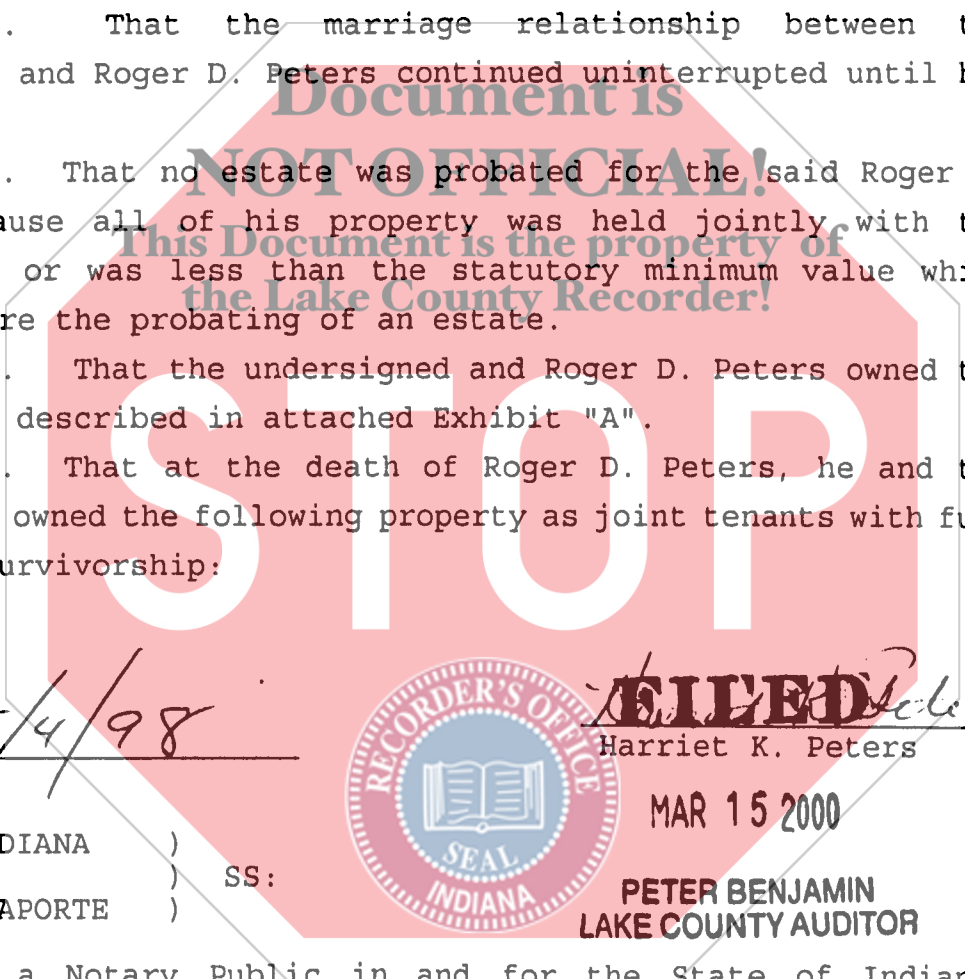
2. 2000 017804

OFFICE OF RECORDER
LAKE COUNTY, INDIANA
2000 017804
MAR 32

AFFIDAVIT

Harriet K. Peters, being first duly sworn upon her oath, alleges and says:

1. That she is the widow of Roger D. Peters who died on January 9, 1998, a resident of Lake County, Indiana.
2. That the marriage relationship between the undersigned and Roger D. Peters continued uninterrupted until his death.
3. That no estate was probated for the said Roger D. Peters because all of his property was held jointly with the undersigned or was less than the statutory minimum value which would require the probating of an estate.
4. That the undersigned and Roger D. Peters owned the real estate described in attached Exhibit "A".
5. That at the death of Roger D. Peters, he and the undersigned owned the following property as joint tenants with full rights of survivorship:



DATED: 5/4/98



Harriet K. Peters
Harriet K. Peters

MAR 15 2000

STATE OF INDIANA)
) SS:
COUNTY OF LAPORTE)

PETER BENJAMIN
LAKE COUNTY AUDITOR

Before me, a Notary Public in and for the State of Indiana, personally appeared Harriet K. Peters this 4th day of May, 1998 and acknowledged the execution of the foregoing affidavit to be her own free act and deed.

My Commission Expires:
3/24/99

Michael V. Riley
Michael V. Riley
Notary Public

This instrument was prepared by Michael V. Riley, Attorney-at-Law, 2510 Oriole Tr., Michigan City, IN 46360; Ph. 879-4925

3135 W. 60th Dr. Men 46410

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* 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. 15-419-14

Local No. 060-45

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

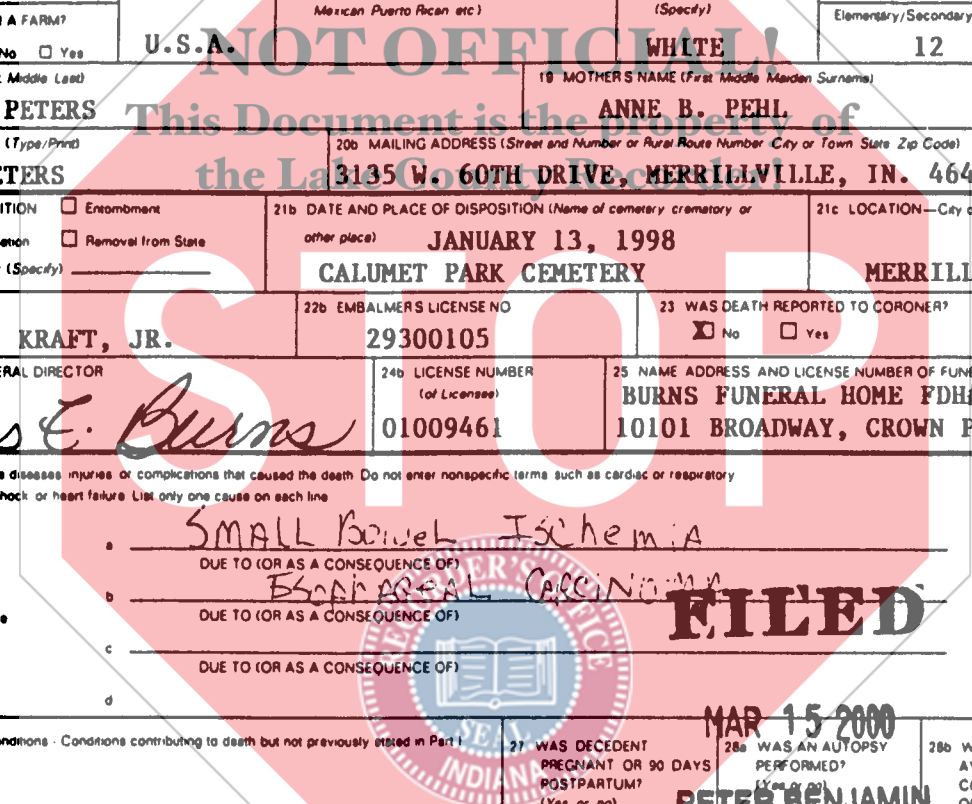
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) ROGER D. PETERS		2 SEX MALE	3a TIME OF DEATH 1:44 P M	3b DATE OF DEATH (Month Day Yr.) JANUARY 9, 1998	
4 *SOCIAL SECURITY NUMBER 311-40-9498	5a AGE—Last Birthday (Years) 57	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr.) AUG. 15, 1940	
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?	9a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" 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) ST. MARY MEDICAL CENTER		9c CITY TOWN OR LOCATION OF DEATH HOBART		9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife give maiden name) HARRIET McLAUGHLIN	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SERVICEMAN		12b KIND OF BUSINESS/INDUSTRY NIPSCO	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY-TOWN OR LOCATION MERRILLVILLE		13d STREET AND NUMBER 3135 W. 60TH DRIVE	
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (14 or 5+)		18 FATHER'S NAME (First Middle Last) GEORGE C. PETERS			
19 MOTHER'S NAME (First Middle Maiden Surname) ANNE B. PEHL		20a INFORMANT'S NAME (Type/Print) HARRIET PETERS			
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 3135 W. 60TH DRIVE, MERRILLVILLE, IN. 46410		20c Relationship WIFE			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place) JANUARY 13, 1998 CALUMET PARK CEMETERY		21c LOCATION—City or Town State MERRILLVILLE, INDIANA	
22a EMBALMER'S NAME RUSSELL A. KRAFT, JR.		22b EMBALMER'S LICENSE NO. 29300105		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24 SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i>		24b LICENSE NUMBER (of Licensee) 01009461	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME FDH#83002445 10101 BROADWAY, CROWN POINT, IN. 46307		
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 SMALL BOWEL ISCHEMIA DUE TO (OR AS A CONSEQUENCE OF)					
b ESOPHAGEAL CARCINOMA 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) 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)	
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>Milton S. Gasparis</i>			
29c MEDICAL LICENSE NO. 01537515		29d DATE SIGNED (Month Day Year) JAN 12 1998			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MILTON GASPARIS, M. D. 1400 S. LAKE PARK AVENUE, HOBART, INDIANA 46342					
31 HEALTH OFFICER'S SIGNATURE <i>Alejandro M. ...</i>					
32 DATE FILED (Month Day Year) <i>January 13, 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 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			



FILED

MAR 15 2000

PETER BENJAMIN LAKE COUNTY AUDITOR