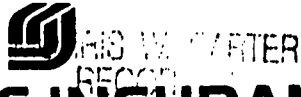


99206525

2000 018275

2000 MAR 17 AM 9:12

69110



TICOR TITLE INSURANCE

TICOR TITLE INSURANCE
Crown Point Indiana

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

KAREN KANE, being first duly
sworn upon oath, deposes and says:

1. That DONALD J. ALBRECHT died on
MARCH 11, 1995, 19 at ST ANTHONY HOSPITAL CROWN POINT

2. That DONALD J. ALBRECHT and PHYLLIS ALBRECHT
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate:

LOTS 196, 198, 213, 233, 234, 235, 236, 238, 239, AND 242, IN CEDAR POINT
PARK, IN THE TOWN OF CEDAR LAKE, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK
15 PAGE 5, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

*K# 25-28-36, 38 + 53, 25-29-11 + 12,
and 25-29-13, 44, 15, 16, 18 + 19.*

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.

Karen Kane
KAREN KANE

Subscribed and sworn to before me, a Notary Public, this 2ND day of
DECEMBER, 1999.

Susan M. Charlebois
SUSAN M. CHARLEBOIS Notary Public

My Commission expires: 09-24-07

FILED

County of Residence:

MAR 16 2000

LAKE

PETER BENJAMIN
LAKE COUNTY AUDITOR

This Instrument prepared by KAREN KANE

01112

11.00
E.P.
Ti

ATTENTION ESTATE: Disclosure of the fact we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

Local No. 0592-95

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) **Donald J. Albrecht**

2 SEX **Male**

3a TIME OF DEATH **3:02 A.**

3b DATE OF DEATH (Month, Day, Year) **March 11, 1995**

4 SOCIAL SECURITY NUMBER **261-26-5696**

5a AGE—Last Birthday (Years) **71**

5b UNDER 1 YEAR **Months Days**

5c UNDER 1 DAY **Hours Minutes**

6 DATE OF BIRTH (Mo, Day, Yr) **March 23, 1923**

7 BIRTHPLACE (City and State or Foreign Country) **Chicago, Illinois**

8a WAS DECEDENT A U.S. VETERAN? **Yes**

8b YEAR LAST SERVED IN U.S. ARMED FORCES? **1945**

8c PLACE OF DEATH (Check only one. See instructions)

HOSPITAL Inpatient Outpatient DCA

OTHER Nursing Home Residence

9a FACILITY NAME (If not extension, give street and number) **St. Anthony Hospital**

9c CITY, TOWN, OR LOCATION OF DEATH **Crown Point**

9d COUNTY OF DEATH **Lake**

10 MARRITAL STATUS **Married**

11 SURVIVING SPOUSE (If wife, give maiden name) **Phyllis Broberg**

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Milkwright**

12b KIND OF BUSINESS/INDUSTRY **Central Steel & Wire Co.**

13a RESIDENCE—STATE **Indiana**

13b COUNTY **Lake**

13c CITY, TOWN, OR LOCATION **Cedar Lake**

13d STREET AND NUMBER **13504 Bryan St.**

13e ZIP CODE **46303**

13f INSIDE CITY LIMITS No Yes

13g ON A FARM? No Yes

14 CITIZEN OF WHAT COUNTRY? **U.S.A.**

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 any highest grade completed)

Elementary/Secondary (10-12) **10**

College (1-4 or 5-8)

18 FATHER'S NAME (First, Middle, Last) **Cyril Gwin Albrecht**

19 MOTHER'S NAME (First, Middle, Maiden Surname) **Bettie Mae Smotherman**

20a INFORMANT'S NAME (Type/Print) **Phyllis Albrecht**

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **13504 Bryan St., Cedar Lake, Indiana 46303**

20c Relationship **Wife**

21a METHOD OF DISPOSITION Entombment Burial Cremation Removal from State Donation Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **March 14, 1995 German Methodist Cemetery**

21c LOCATION—City or Town, State **Cedar Lake, Indiana**

22a EMBALMER'S NAME **Fred Oraska**

22b EMBALMER'S LICENSE NO. **FD01016076**

23 WAS DEATH REPORTED TO CORONER? No Yes

24a SIGNATURE OF FUNERAL DIRECTOR **Fred Oraska**

24b LICENSE NUMBER (of Licensee) **FD01016076**

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME **Ellen Brady Funeral Home, Inc. FR83000825 8510 Lakeshore dr. Cedar Lake, Indiana 46303**

26 PART I Enter the disease, injury, 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. **Congestive Cardomyopathy**

b. DUE TO (OR AS A CONSEQUENCE OF)

c. DUE TO (OR AS A CONSEQUENCE OF)

d. DUE TO (OR AS A CONSEQUENCE OF)

DATE **MAR 17 1995**

26 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 WERE AUTOPSY FINDINGS DISCLOSED PRIOR TO RELEASE OF CAUSE OF DEATH? (Yes or no) **No**

28b WERE AUTOPSY FINDINGS DISCLOSED TO CORONER? (Yes or no) **No**

29a CERTIFIER 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) as stated.

29b SIGNATURE AND TITLE OF CERTIFIER **Shannon Mc Carthy MD**

29c MEDICAL LICENSE NO. **21031401**

29d DATE SIGNED (Month, Day, Year) **3/15/95**

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type/Print) **Shannon M. Carthy 1911 1/2 Broadway, Merrillville, IN 46411**

31 HEALTH OFFICER'S SIGNATURE **William D. Williams, M.D.**

32 DATE FILED (Month, Day, Year) **March 15, 1995**

33 MANNER OF DEATH

Natural Pending investigation

Accident Suicide Homicide

Sudden Could not be Determined

34a DATE OF INJURY (Month, Day, Year)

34b TIME OF INJURY

34c INJURY AT WORK? (Yes or no)

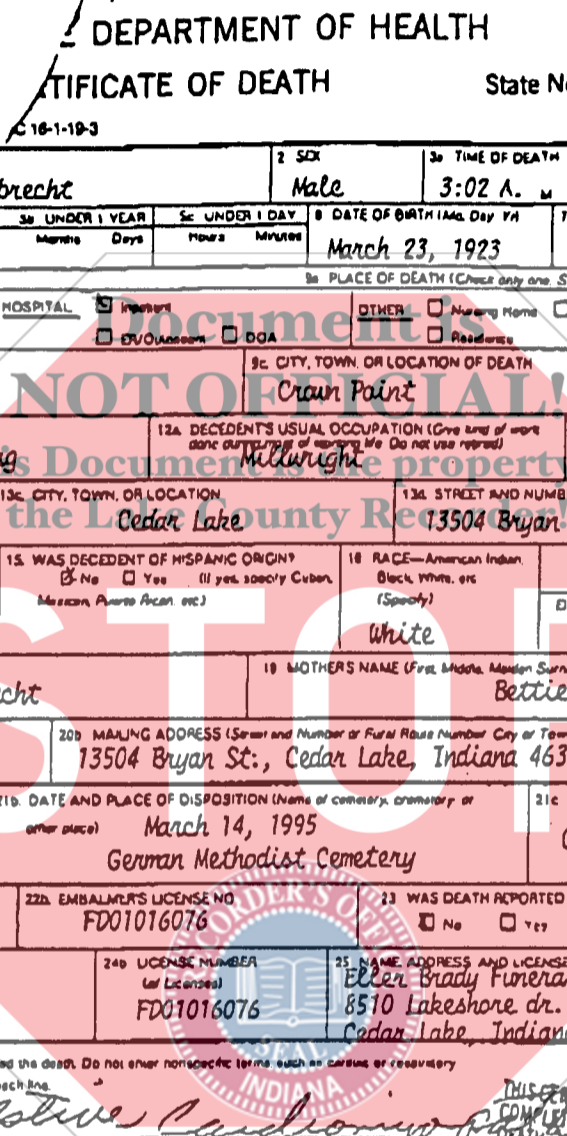
34d DESCRIBE HOW INJURY OCCURRED

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)

35g DATE PRONOUNCED DEAD (Month, Day, Year)

35h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.



USE OF THIS

CERTIFIER

THICER