STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 018275

2000 MAR 17 AM 9:12

99206525

6910

AND MAIL AFTER RECORDING TO:

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+123;
and 25-29-13, 14, 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, 19 99.

Susan M. Charlebois
SUSAN M. CHARLEBOIS Notary Public

My Commission expires: 09-24-07

County of Residence:

LAKE

This Instrument prepared by KAREN KANE

FILED

MAR 16 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

11.00 E.P.

01112

ITTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities voluntary and there will be no penalty for fusal.*

DEPARTMENT OF HEALTH

TIFICATE OF DEATH

xcal No. 0592-95 State No. .....

THE RECORDS IN THIS SERIES AR... IC 16-1-19-3

YPE/PRINT IN ERMANENT BLACK INK

CEDENT

1 DECEASED—NAME (First, Middle, Last): Donald J. Albrecht			2 SEX: Male	3a TIME OF DEATH: 3:02 A. M	3b DATE OF DEATH (Month, Day, Yr.): 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	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)			
9b FACILITY NAME (If not institution, give street and number): St. Anthony Hospital		9c CITY, TOWN, OR LOCATION OF DEATH: Crown Point		9d COUNTY OF DEATH: Lake	
10 MARITAL STATUS (Specify): 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): Millwright		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 only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
18 FATHER'S NAME (First, Middle, Last): Cyril Quin 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 Oparka		22b EMBALMER'S LICENSE NO: FD01016076		23 WAS DEATH REPORTED TO CORONER? ☐ No ☐ Yes	
24a SIGNATURE OF FUNERAL DIRECTOR: Fred Oparka		24b LICENSE NUMBER (of Licensee): FD01016076		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Elder Brady Funeral Home, Inc. FH83000825 8510 Lakeshore dr. Cedar Lake, Indiana 46303	

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. Congestive Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
b.
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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

MAR 17 1995

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 AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

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)
Shannon Mc Carthy MD	31031401	3/15/95

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Shannon M'Carthy 9811 Broadway, Merrillville IN 46410

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Alexander D. Williams, M.D.	March 15, 1995

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.

SDH06 004 State Form 10110 (R4/3-93) Deathcer/PD 1