

2000 018281

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2000 MAR 17 AM 9:13

MORRIS W. CARTER



# TICOR TITLE INSURANCE

## AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Susan L. Watkins, being first duly  
sworn upon oath, deposes and says:

1. That Ann Cress died on  
July 18, 19 99 at Munster, Indiana.

2. That Joseph A. Cress and Ann Cress  
were duly and legally married at the time they acquired title as husband and  
wife to the following described real estate:

Lot 14, Block 1, Knickerbocker Manor 7th Addition to the Town of Munster,  
as shown in Plat Book 32, page 56 in the Office of the Recorder of Lake  
County, Indiana.

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 ~~xxxx~~ (her) death.

4. 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.

Susan L. Watkins  
Susan L. Watkins

Subscribed and sworn to before me, a Notary Public, this 7th day of  
March, ~~19~~ 2000.



Susan M. Downing  
Susan M. Downing Notary Public

My Commission expires:

4/10/07

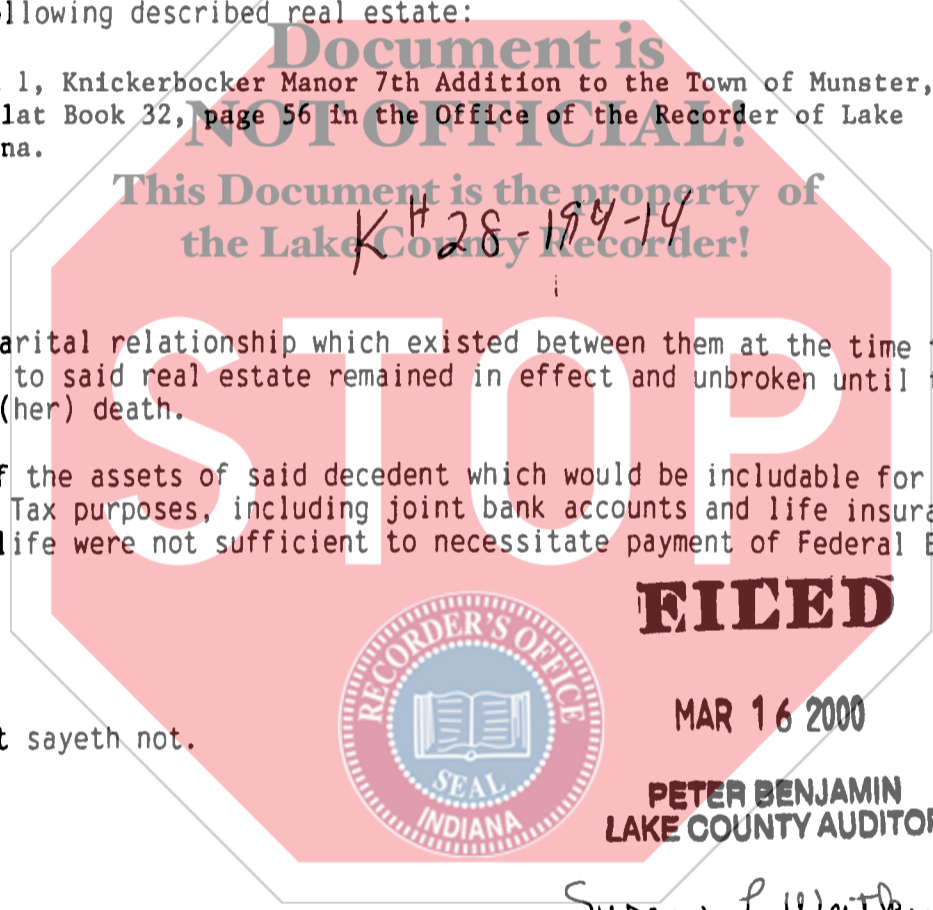
County of Residence:

Lake

This Instrument prepared by Susan L. Watkins

Balloon: H/O  
200018T

BURNET TITLE



11.00  
P.T.

\* ATTENTION ESTATE: This 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. 1701-99

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

264570 TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (From Medical List) Ann Cross

2 SEX Female

3a TIME OF DEATH 10:05PM

3b DATE OF DEATH (Month, Day, Year) July 18, 1999

4 SOCIAL SECURITY NUMBER 350-14-3142

5a AGE—Last Birthday (Years) 76

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo, Day, Yr) March 28, 1923

7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN

8a WAS DECEASED A U.S. VETERAN? No

8b YEAR LAST SERVED IN U.S. ARMED FORCES? None

9a PLACE OF DEATH (Check only one. See instructions)  
 HOSPITAL  Inpatient  ER/Outpatient  DOA  
 OTHER  Nursing Home  Other (Specify)

9b FACILITY NAME (If not institution, give street and number) Riley Hospice Residence

9c CITY, TOWN OR LOCATION OF DEATH Munster

9d COUNTY OF DEATH Lake

10 MARITAL STATUS (Specify) Married

11 SURVIVING SPOUSE (If with give present name) Joseph Cross

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

12b KIND OF BUSINESS/INDUSTRY Home

13a RESIDENCE—STATE IN

13b COUNTY Lake

13c CITY, TOWN OR LOCATION Munster

13d STREET AND NUMBER 8522 Forest Ave.

13e ZIP CODE 46321

13f INSIDE CITY LIMITS  No  Yes

13g ON A FARM?  No  Yes

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

15 WAS DECEASED OF HISPANIC ORIGIN?  No  Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)

16 RACE—American Indian, Black, White, etc. (Specify) White

17 DECEASED'S EDUCATION (Specify any highest grade completed)  
 Elementary/Secondary (10, 12) 12 College (1-4 or 5+) 2

18 FATHER'S NAME (From Medical List) Leon Maslanka

19 MOTHER'S NAME (From Medical List, Maiden Surname) Maria Piskoroska

20a INFORMANT'S NAME (Type/Print) Joseph Cross

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 8522 Forest Ave. Munster, IN 46321

20c Relationship Husband

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) July 22, 1999 Regional Cremation SV

21c LOCATION—City or Town, State Munster, IN

22a EMBALMER'S NAME John T. Noble

22b EMBALMER'S LICENSE NO. 9000031

23 WAS DEATH REPORTED TO CORONER?  No  Yes

24 SIGNATURE OF FUNERAL DIRECTOR (Signature)

24b LICENSE NUMBER (of Licensee) 1021590

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968  
8415 Calumet Munster, IN 46321

26 PART I Enter the diseases, injuries or combinations 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.  
 IMMEDIATE CAUSE (If not disease or condition, list the ASOVEIS, a stroke, a fall, etc., resulting in death.)  
 GIBBASTOMA MULTIFOCAL LYON  
 COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT  
 DUE TO (OR AS A CONSEQUENCE OF)  
 JUL 22, 1999  
 DUE TO (OR AS A CONSEQUENCE OF)

26 PART II Other significant conditions, conditions contributing to death but not previously stated in Part I  
 Alex. S. Williams, M.D. LAKE COUNTY HEALTH COMMISSIONER

27 WAS DECEASED 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)  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 (Signature)

29c MEDICAL LICENSE NO. 201031582

29d DATE SIGNED (Month, Day, Year) July 22, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Lyle Munn, M.D. 600 Superior Ave. Munster, IN 46321

31 HEALTH OFFICER'S SIGNATURE (Signature) Alexander S. Williams, M.D.

32 DATE FILED (Month, Day, Year) July 22, 1999

33 MANNER OF DEATH  Natural  Pending Investigation  Accidental  Suicide  Homicide  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

34a PLACE OF INJURY—(A) home farm street factory office building etc. (Specify)

34b LOCATION (Street and Number or Rural Route Number, City or Town, State)

35 DATE PRONOUNCED DEAD (Month, Day, Year)

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