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FILED

STATE OF INDIANA
LAKE COUNTY MAR 22 2000
FILED FOR RECORD

2000 019809

2000 MAR 23 AM 9 PETER BENJAMIN
LAKE COUNTY AUDITOR

MORRIS W. CARTER
RECORDER

AFFIDAVIT

I, **David L. Gilbert**, hereby certify the following to be true and correct.

The Gilbert Living Trust was created July 2, 1992 naming Co-trustees as **Sanford L. Gilbert** and **Mary Catherine Gilbert,** Husband and Wife.

Sanford L. Gilbert passed away June 27, 1997, leaving **Mary Catherine Gilbert** trustee.

On September 16, 1997, **Mary Catherine Gilbert** resigned as trustee there upon appointing **David L. Gilbert** as Successor Trustee.

Key # 11-160-5

D. David L. Gilbert T.R.
Signature

David L. Gilbert, Trustee
Printed

Title

State of INDIANA)
) SS:
County of LAKE)

The foregoing Affidavit was acknowledged before me on this 17th day of March, 2000 by **David L. Gilbert**

PAULA BARRICK NOTARY EXP. 10/2/01 PUBLIC LAKE COUNTY, INDIANA

Paula Barrick
Notary Public Paula Barrick

My Commission Expires:
10-2-01

County of Residence:
Lake

01457

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E.P.
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This document was prepared by: David L. Gilbert

Ticor M.O. 920000869 Gilbert

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C#4048	6

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 1374-97

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	Sanford L. Gilbert
2. SEX	Male
3a. TIME OF DEATH	11:20 P M
3b. DATE OF DEATH (Month, Day, Yr)	June 27, 1997
4. *SOCIAL SECURITY NUMBER	262-36-4941
5a. AGE—Last Birthday (Years)	66
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	Dec 30, 1930
7. BIRTHPLACE (City and State or Foreign Country)	Florida
8a. WAS DECEDENT A U.S. VETERAN?	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1953
9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☒ Other (Specify) ☐ Residence	Street
9b. FACILITY NAME (If not institution, give street and number)	8810 Patterson Street
9c. CITY, TOWN, OR LOCATION OF DEATH	St. John
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Mary Catherine Parker
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Salesman
12b. KIND OF BUSINESS/INDUSTRY	Sales
13a. RESIDENCE—STATE	IN
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	St. John
13d. STREET AND NUMBER	8399 Patterson
13e. ZIP CODE	46373
13f. INSIDE CITY LIMITS	☒ No ☐ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	12

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Sanford Gilbert
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Buelah Cranger

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Mary Catherine Gilbert
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8399 Patterson St. John, IN 46373
20c. Relationship	Wife

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	July 3, 1997 Lowell Memorial Cemetery
21c. LOCATION—City or Town, State	Lowell, IN
22a. EMBALMER'S NAME	Kenneth P. Sheets
22b. EMBALMER'S LICENSE NO.	FD08900045
23. WAS DEATH REPORTED TO CORONER?	☐ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Ken Sheets
24b. LICENSE NUMBER (of Licensee)	FD08900045
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN

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.

		Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	Extensive blunt force trauma	Unknown
	b	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	Yes	Yes

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.
Deputy ☒ 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)
Donna Melyon	N/A	July 1, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Donna Melyon, Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alejandro S. Williams, MD
32. DATE FILED (Month, Day, Year): 1997

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)	June 27,1997
34b. TIME OF INJURY	Unknown
34c. INJURY AT WORK? (Yes or no)	No
34d. DESCRIBE HOW INJURY OCCURRED	Vehicle accident. Lost control passing a car, struck utility pole, ejected, struck by auto.
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	Street
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	8810 Patterson Street St. John, Indiana
34g. DATE PRONOUNCED DEAD (Month, Day, Year)	June 27, 1997
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.	Yes Driver

THIS CERTIFIES THAT THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPT.

Alejandro S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

01458

FILED
MAR 22 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

Key # 11-160-5

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

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