

FA# F31403

LEGAL DESCRIPTION **2000 020754**

2000 MAR 27 AM 10:13

Lot 2, in the Southgate Estates 1st Addition, as per plat thereof recorded in Plat Book 35, page 103, in the Office of the Recorder of Lake County, Indiana.

MORRIS V. CARTER
RECORDER



First American Title
Insurance Company

PROPERTY ADDRESS:

8239 Old Lincoln Highway, Hobart, IN 46342

ESTATE AFFIDAVIT

REBECCA LYNN DOLNICS, Affiant, states that:

1. Muriel J. Huff, deceased, died on the 15th day February 1988

of

daughter

2. Affiant is: the surviving ~~spouse~~ of the deceased,

the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;

4. The deceased and Affiant were married on the *23rd* day of *August* of *1954*; and were never divorced.
(This item applies only to the surviving spouse.)

5. All expenses of the last illness and funeral of the deceased have been paid;

6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. There have been no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

03/22/2000

Date

3-22-2000

Signature of Affiant

Rebecca Lynn Dolnics

REBECCA LYNN DOLNICS ATTORNEY-IN-FACT

Printed Name of Affiant

FOR JAMES A. HUFF a/k/a
JAMES D. HUFF

State of Indiana, County of Porter

Subscribed and sworn to before me, this 22nd day of March, 2000.

Lori S. Monahan

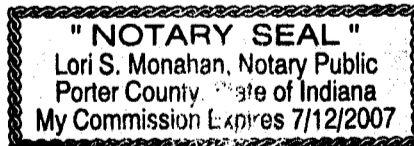
Printed Name of Notary

Lori S. Monahan

Signature of Notary

My Commission expires: 07/12/2007

My County of Residence is: Porter



THIS INSTRUMENT WAS PREPARED BY: Rebecca Lynn Dolnics

F31403 lsm

HOLD FOR FIRST AMERICAN TITLE

FILED

MAR 27 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR



11-00
MK
7/11
2023

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

80012

Local No. 350-88

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING
PHYSICIAN ONLY

ITEMS 24-26 MUST
BE COMPLETED BY
PERSON WHO
PRONOUNCES DEATH

SEE INSTRUCTIONS
ON CERTIFICATE TO
OBTAIN COMPLETE COPY
WITH ORIGINAL ON FILE
WITH DEPT.

CAUSE OF
DEATH

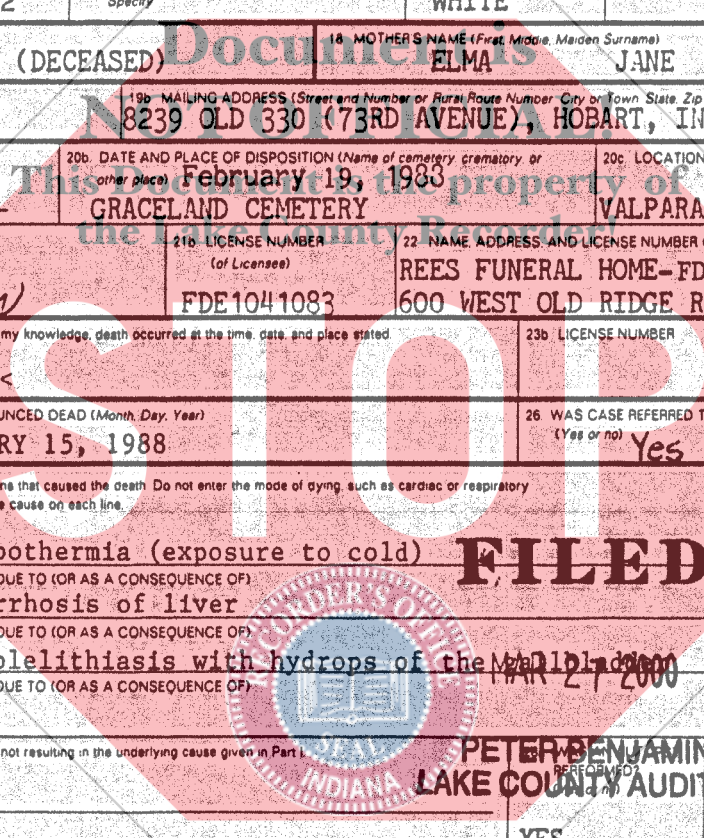
SEE INSTRUCTIONS
ON COUNTY HEALTH
COMMISSIONER

CERTIFIER

HEALTH
OFFICER

CRONER OR
MEDICAL
EXAMINER USE
ONLY

1 DECEASED—NAME FIRST MURIEL MIDDLE JOYCE LAST HUFF			2 SEX Female	3 DATE OF DEATH (Mo Day Yr) February 15, 1988
4 SOCIAL SECURITY NUMBER 312-34-4044	5a AGE—Last Birthday (Years) 50	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) 12-18-1937
8 YEAR LAST SERVED IN U.S. ARMED FORCES? NO		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) BROADWAY METHODIST HOSPITAL		9c CITY TOWN OR LOCATION OF DEATH MERRILLVILLE	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS—Married Never Married, Widowed, Divorced (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) JAMES HUFF	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) HOMEMAKER	12b KIND OF BUSINESS/INDUSTRY NONE	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION HOBART	13d STREET AND NUMBER 8239 OLD 330 (73RD AVENUE)	
13e INSIDE CITY LIMITS? (Yes or no) NO	13f FARM NO	13g ZIP CODE 46342	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes specify Cuban, Mexican, Puerto Rican, etc.) No	15 RACE—American Indian, Black White, etc (Specify) WHITE
17 FATHER'S NAME (First Middle Last) ROBERT SMITH (DECEASED)		18 MOTHER'S NAME (First Middle Maiden Surname) ELMA JANE RYTHER		
19a INFORMANT'S NAME (Type/Print) JAMES HUFF		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8239 OLD 330 (73RD AVENUE), HOBART, INDIANA 46342	19c Relationship SPOUSE	
20a 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)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) February 19, 1988 GRACELAND CEMETERY	20c LOCATION—City or Town, State VALPARAISO, INDIANA	
21a SIGNATURE OF FUNERAL DIRECTOR <i>Gerald V. Ross</i>		21b LICENSE NUMBER (of Licensee) FDE1041083	22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOME—FDH3003069 600 WEST OLD RIDGE RD., HOBART, IN 46341	
23a To the best of my knowledge, death occurred at the time, date, and place stated Signature and Title <		23b LICENSE NUMBER	23c DATE SIGNED (Month, Day, Year)	
24 TIME OF DEATH 02:44P M	25 DATE PRONOUNCED DEAD (Month, Day, Year) FEBRUARY 15, 1988	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) Yes		
27 PART I Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a Hypothermia (exposure to cold) DUE TO (OR AS A CONSEQUENCE OF) b Cirrhosis of liver DUE TO (OR AS A CONSEQUENCE OF) c Cholelithiasis with hydrops of the gallbladder DUE TO (OR AS A CONSEQUENCE OF) d				Approximate Interval Between Onset and Death Undetermined
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 18 1988				28 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes
29a CERTIFIER (Check only one) <i>[Signature]</i>		29b DATE SIGNED (Month, Day, Year) February 17, 1988		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) DANIEL THOMAS MD, 2293 NORTH MAIN STREET, CROWN POINT, INDIANA 46307		31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		
32 DATE FILED (Month, Day, Year) 2/18/88		33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" 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) Feb. 16, 1988		34b TIME OF INJURY No	34c INJURY AT WORK? (Yes or no) No	
34d DESCRIBE HOW INJURY OCCURRED street		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) 8239 Old Lincolnway, Hobart, Indiana		



FILED
MAR 27 2000
LAKE COUNTY AUDITOR

2024