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2000 022631

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2000 APR -3 PM 12:5_
MORRIS W. CARTER
RECORDER

FILED
MAR 31 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

SURVIVORSHIP AFFIDAVIT

LTIC 00-01356

Hobart, INDIANA
(City)

STATE OF INDIANA, COUNTY OF Lake, SS:

Dolores Chapman-Graves, being first duly sworn, on oath states that Dolores is of lawful age and resides in the County of Lake, State of Indiana. That Dolores is the surviving ~~spouse~~ Daughter of Lucille Kramer who died on the 8th day of April, 1999, and that ~~as such surviving spouse, is the owner of the following real estate located in ______ County, Indiana.~~ her life estate is now extinguished

SEE ATTACHED EXHIBIT A

THE EAST 80 FEET OF LOT 1 IN BLOCK 13 IN JAKE KRAMER, JR. ADDITION TO HOBART AS PER PLAT THEREOF RECORDED IN PLAT BOOK 11, PAGE 22, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

That all debts, funeral expenses and doctor bills of said decedent have been fully paid and satisfied, and that said decedent's estate has not been and is not to be administered upon.

That the decedent and this affiant were husband and wife at the time they took title to the above described real estate and that they remained such continuously until the death of said decedent.

3-29-00
Date

Dolores M. Chapman-Graves
Dolores M. Chapman-Graves Affiant
Who took Title As Dolores M. Chapman

Before me, Michaelene T. F, a Notary Public in and for said County, personally appeared Dolores M. Chapman-Graves this 29 day of March, 2000 and acknowledged the foregoing document to be his/her voluntary act and deed.

[signature]
Notary Public
MICHAELENE T. FAZEKAS
NOTARY PUBLIC STATE OF INDIANA
Resident of Lake County
My Commission Expires 7-24-01

My commission expires: ______
Resident of ______ County

This document prepared by: Dolores M. Chapman-Graves

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02412

11.00

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

EXHIBIT A

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

12cc

Local No. 103-99   LTIC 00-01356   State No. ....

264518

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED-NAME (First Middle Last): LUCILLE M. KRAMER
- 2. SEX: Female
- 3a. TIME OF DEATH: 11:30AM
- 3b. DATE OF DEATH (Month Day Yr): April 8, 1999
- 4. SOCIAL SECURITY NUMBER: 313-34-4814
- 5a. AGE - Last Birthday (Years): 87
- 5b. UNDER 1 YEAR (Months, Days):
- 5c. UNDER 1 DAY (Hours, Minutes):
- 6. DATE OF BIRTH (Mo Day Yr): February 3, 1912
- 7. BIRTHPLACE (City and State or Foreign Country): Moline, Illinois
- 8a. WAS DECEDENT A U.S. VETERAN?: No
- 8b. YEAR LAST SERVED IN U.S. ARMED FORCES: N/A
- 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): 1300 State Street
- 9c. CITY TOWN OR LOCATION OF DEATH: Hobart
- 9d. COUNTY OF DEATH: Lake
- 10. MARITAL STATUS (Specify): Widowed
- 11. SURVIVING SPOUSE (If wife, give maiden name): NONE
- 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: Home
- 13a. RESIDENCE - STATE: Indiana
- 13b. COUNTY: Lake
- 13c. CITY TOWN OR LOCATION: Hobart
- 13d. STREET AND NUMBER: 1300 State Street
- 13e. ZIP CODE: 46342
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: USA
- 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): 12; College (1-4 or 5+):

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): Einar Greko
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Dereks

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): Dolores Graves
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 155 S. Virginia Street, Hobart, IN 46342
- 20c. Relationship: Daughter

DISPOSITION

- 21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): April 12 1999, Calumet Park Cemetery
- 21c. LOCATION (City or Town State): Merrillville, Indiana
- 22a. EMBALMER'S NAME: James J. Krause
- 22b. EMBALMER'S LICENSE NO.: FDO1006463
- 23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: [signature] James J. Krause
- 24b. LICENSE NUMBER (of Licensee): FDO1006463
- 25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069, Rees Funeral Home, Inc., 600 W. Old Ridge Road, Hobart, IN 46342

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Scleroderma

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Coronary Artery disease, Raynaud's Phenomenon

- 27. WAS DECEDENT 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): No

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.
- ☐ 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: 01033175
- 29d. DATE SIGNED (Month Day Year): April 13, 1999
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): P. K. Alexander MD, 7550 Hohman Avenue, Munster, IN 46321 — H 97.2744

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Alexander S Williams MD
- 32. DATE FILED (Month Day Year): 4/13/99

- 33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
- 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):
- 34g. DATE PRONOUNCED DEAD (Month, Day, Year):
- 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

02413

SDH06-004   State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

LAWYERS TITLE INS. CORP, ONE PROFESSIONAL CENTER, SUITE 215, CROWN POINT, IN 46307

ZKL OCT 0 1999 CLAIM DEPT.

FILED MAR 3 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

I CERTIFY THIS IS A COMPLETE COPY OF DEATH ON FILE WITH HEALTH DEPT. APR 13 1999 Alexander S. [signature]

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RECORDER'S OFFICE LAKE COUNTY INDIANA SEAL