26-36-0155-0012

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 026123

2000 APR 17 PM 1:43

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SURVIVORSHIP AFFIDAVIT

COMES NOW the affiant, BARBARA A. ROBARE, who being first sworn and upon his/her oath and under penalties for perjury, solemnly swears and states that :

1. He/She is the legal title owner of the real estate located at 4750 ELM AVENUE HAMMOND, IN 46327, more particularly described as follows, to wit:
   SEE APPENDIX A Lot Number 14 and The North half of Lot Number 13, in Block 1, As marked and Laid down on The recorded plat of Steenberg's Addition to Hammond, in Lake County, Indiana Plat book 9 Page 35.

2. He/She acquired title to the afore-mentioned real estate with his/her husband/wife by Warranty Deed dated APRIL 27, 1998 and recorded MAY 6, 1998 Instrument No. 98032920, in the Office of the Recorder of LAKE County, Indiana.

3. He/She and his/her husband/wife, WILLIAM M. ROBARE, held title by the entireties until the date of his/her death on APRIL 10, 1999.

4. By virtue of the operation of law in the he/she is the survivor of them, the affiant should now be shown as the sole owner of the real estate.

5. The total value of my late husband's/wife's estate, including the proceeds of life insurance, and interests in jointly owned real estate, was not large enough to be subject to federal estate tax.

Affiant makes these statements to induce the appropriate governmental authorities to cause the title to the real estate to be shown in the sole name of the affiant and that all tax records be shown accordingly.

APRIL 6, 2000
Date

Barbara A. Robare
(Print Name) BARBARA A. ROBARE

FILED
APR 17 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA)
SS:
COUNTY OF LAKE)

Before me, a Notary Public, in and for said State and County, personally appeared the affiant herein, BARBARA A. ROBARE, who acknowledge the truthfulness of the contents herein.

Witnessed this 6TH day of APRIL 2000,

My Commission Expires: 08-01-07

PAMELA L. STANFORD
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY
MY COMMISSION EXP. AUG. 1,2007

Pamela L. Stanford
Notary Public

Resident of LAKE County

Prepared BY: BARBARA A. ROBARE

Return to: Sand Ridge Bk
P.O. Box 598, Schererville IN 46375

11.00 E.P.

#840

50937

[redacted]

* ATTENTION ESTATE: The 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

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

SI May 20, 1999 Date Issued — Franklin D. Grenuda, Hammond Health Commission

Local No. 329

RESUBMIT TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

DECEDENT

1 DECEASED—NAME (First, Middle, Last): William M. Robare, III

2 SEX: Male

3a TIME OF DEATH: 9:20 A.M.

3b DATE OF DEATH (Month, Day, Yr.): April 10, 1999

4 SOCIAL SECURITY NUMBER: 319-48-5754

5a AGE—Last Birthday (Years): 45

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo. Day. Yr.): Dec. 14, 1953

7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois

8a WAS DECEDENT A US VETERAN?: No

8b YEAR LAST SERVED IN US ARMED FORCES?: None

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

9b FACILITY NAME (If not institution, give street and number): Residence: 4750 Elm Street

9c CITY, TOWN, OR LOCATION OF DEATH: Hammond

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Barbara Cutrara

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Self-employed

12b KIND OF BUSINESS/INDUSTRY: Scrapper

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY, TOWN OR LOCATION: Hammond

13d STREET AND NUMBER: 4750 Elm Street

13e ZIP CODE: 46327

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): 12; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): William M. Robare, II

19 MOTHER'S NAME (First, Middle, Maiden Surname): Arlene Porter

INFORMANT

20a INFORMANT'S NAME (Type/Print): Mrs. Barbara Robare

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4750 Elm Street, Hammond, IN 46327

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): April 14, 1999 Northwest Indiana Cremation Service

21c LOCATION—City or Town, State: Crown Point, Indiana

22a EMBALMER'S NAME: C. William McCoy

22b EMBALMER'S LICENSE NO: FD01013612

23 WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): FD01042047

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bucken Funeral Home, Inc. FH8300280, 7042 Kennedy Ave., Hammond, IN 4632

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cirrhosis of liver with hepatic failure — Approximate Interval Between Onset and Death: Unknown

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF):
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): No

28a WAS AN AUTOPSY PERFORMED? (Yes or no): Yes

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

CERTIFIER

29a CERTIFIER (Check only one): Deputy
☐ 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: Helen M. Sanok

29c MEDICAL LICENSE NO: N/A

29d DATE SIGNED (Month, Day, Year): May 13, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Helen M. Sanok, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Grenuda M.D.

32 DATE FILED (Month, Day, Year): May 20, 1999

33 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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:

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): April 10, 1999

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.:

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