STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 029830 2000 MAY -3 AM 9:12

TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

BETTY LOU CARRELL, being first duly sworn upon oath, deposes and says:

1. That **WILLIAM F. CARRELL** died on 8-19-98, 19____ at St Margaret Mercy Hammond

2. That **WILLIAM F. CARRELL** and **BETTY LOU CARRELL** were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOTS 35 AND 36 IN BLOCK 1 IN SOUTH HAMMOND SUBDIVISION, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 2 PAGE 38, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

Key # 36-78-30

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 (his) ~~(her)~~ death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. 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.

Betty Lou Carrell
BETTY LOU CARRELL

Subscribed and sworn to before me, a Notary Public, this **28TH** day of **APRIL, 2000**, 19 91.

Karen Kane
KAREN KANE Notary Public

My Commission expires:

9/12/07

County of Residence:

PORTER

FILED

MAY 02 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

This Instrument prepared by **BETTY LOU CARRELL**

11.00 E.P. T1

TICOR TITLE INSURANCE
Crown Point, Indiana
92000608

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.

Local No. 1627

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Date Issued 8/20/1998 — Franklin D. Bermudez M.D. Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-9

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
William	F.	Carrell	Male	3:50P	August 19, 1998

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
348-18-8467	73			June 12, 1925	Xenia, IL

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
Yes	1946	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Margaret Mercy - North Campus	Hammond	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Betty L. Galbraith	Carpenter	Local # 599

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	527 Mulberry St.,

13e ZIP CODE	13f INSIDE CITY LIMITS?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46324	13g ON A FARM? ☒ No ☐ Yes	USA	☒ No ☐ Yes	White	10	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Oliver Carrell	Ehuna Wilkerson

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Betty L. Carrell	527 Mulberry St., Hammond, IN 46324	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment	August 23, 1998 Elmwood Cemetery	Flora, IL

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Henry J. Blake	FD01019406	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Eldon V. LaHayne	FD01041928	LaHayne Funeral Home, Inc., FH8300288 5746 Hohman Ave., Hammond, IN 46320

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. CARDIO RESPIRATORY ARREST	IMMEDIATE
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	b. NEUROBLASTOMA	FOR WEEKS
	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

THROMBOCYTOPENIA
ANEMIA

27 WAS DECEDENT PREGNANT OR WITHIN 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	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
☐ MEDICAL EXAMINER 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
	1029974	8-19-98 (AUGUST)

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
M. M. Shah M.D. 5500 Hohman Ave. Ste 2E Hammond, Indiana 46320

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Bermudez M.D.	August 20, 1998

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or No)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

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