2

COMMUNITY TITLE COMPANY

— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 050890

AFFIDAVIT

2000 JUL 18 AM 10:11

MORRIS W. CARTER
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

GARY A. EVANS, being first duly sworn upon oath, deposes and says:

1. That Affiant's ~~xxxxxxx~~ AUNT, STELLA (H.) KREAGER died (without leaving a will) ~~xxxxxxxxxxxxxxxx~~ on MAY 23rd 1997 at COMMUNITY HOSPITAL, MUNSTER, INDIANA.

2. That ~~(she)xxx~~ CHARLES KREAGER AND STELLA (H.) KREAGER, were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

THE EAST 15 FEET OF LOT 2, ALL OF LOT 3 AND THE WEST 5 FEET OF LOT 4 IN BLOCK 2 IN ROXANA 1st ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED AUGUST 13, 1926 IN PLAT BOOK 20 PAGE 24, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 2710-173rd ST., HAMMOND, IN. 46323

UNIT 26 KEY NO. 35-358-3

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.

FILED

JUL 12 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

Further affiant sayeth not.

GARY A. EVANS

Subscribed and sworn to before me, a Notary Public, this 7th day of July, 19 2000.

COMMUNITY TITLE COMPANY
FILE NO 2 19611 MV

Patricia Ludington Notary Public

My Commission expires:
04/15/08

County of Residence:
LAKE

1 20707

11 00
AC

This Instrument prepared by PATRICK McMANAMA, ATTORNEY AT LAW
ID 9534-45

CM

* **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

Local No. 1099-97 203243

State No. .....

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
STELLA H. KREAGER	Female	9:20 A M	May 23, 1997

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)
306-16-7662	88			March 23, 1909	Hammond, Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
No	----------	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
Community Hospital	Munster	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	Charles Kreager	Department Manager	Goldblatt's Dept.Store

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hammond	2710-173rd Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	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+)
46323	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	8th

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Lawrence Selva	Margaret Glowacki

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
Charles Kreager	2710-173rd St., Hammond, Indiana 46323	Husband

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 ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 28, 1997 Holy Cross Cemetery	Calumet City, Illinois

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Dean G. Wagner	8800057	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John L. Grey	1007231	Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, In. 46324

CAUSE OF DEATH

26. PART I. ~~THIS CERTIFIES THE ABOVE FACTS AND COMPARES COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT~~ Enter the chain of events—diseases, injuries, or complications—that directly caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (disease or condition resulting in death)	Advanced ovarian cancer	1 year
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): MAY 28 1997	
	DUE TO (OR AS A CONSEQUENCE OF):	
	DUE TO (OR AS A CONSEQUENCE OF): Alexander S. Killian, M.D. LAKE COUNTY HEALTH COMMISSIONER	

PART II. Other significant 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)
Cerebrovascular accident	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
DJH MD	IN 33702	5-27-97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Don M. Henry, M.D. 800 McCarthy Blvd., Munster, Indiana 46321 836-5512

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander S. Killian, M.D.	May 28, 1997

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.