TICOR TITLE INSURANCE

AFFIDAVIT

2000 059804

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Muriel Edith Treadwell, being first duly sworn upon oath, deposes and says:

1. That Doris C. Robinson died on April 4, 2000 at Gary, IN.

2. That Muriel Edith Treadwell and Doris C. Robinson were duly and legally married at the time they acquired title as husband and wife to the following described real estate: Joint tenants

The North 15 feet of Lot 70 and all of Lots 71, 72 and 74 in Block 3 in Lincoln Park Addition to Gary, as per plat thereof, recorded in Plat Book 6 page 17, in the Office of the Recorder of Lake County, IN.

Key No. 45-320-18, 20 and 22.

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.

FILED
AUG 17 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

Muriel Edith Treadwell
Muriel Edith Treadwell

Subscribed and sworn to before me, a Notary Public, this 14th day of August, 2000.

LINDA J. McBRIDE NOTARY PUBLIC LAKE COUNTY, INDIANA 01/26/2007

Linda J. McBride Notary Public

My Commission expires:

1-26-07

County of Residence:

Lake

01147

11.00 EP. T

This Instrument prepared by Muriel Edith Treadwell

Ticor M.O. 920002420
Patterson

10cc

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. 00-0259 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)
Doris	C.	Robinson	Female	7:50P M	April 4,2000

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)
358-18-0508	73			March 20,1927	Joliet,Illinois

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	N/A	HOSPITAL XX 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
Methodist Hospital Northlake	Gary	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
Widowed	N/A	Teacher	Gary Community School

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Gary	2652 Buchanan 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 +)
46407	XX No ☐ Yes	XX No ☐ Yes	U S A	XX No ☐ Yes	Black		5 +

PARENTS

18 FATHER'S NAME (First Middle Maiden Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Charles C. Crusoe	Annie L. Brooks

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
Muriel Treadwell	2255 Fullerton Circle Indianapolis,Indiana 46214	Daughter

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
☐ Entombment XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____	April 10,2000 Evergreen Cemetery	Hobart,Indiana

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Roosevelt Allen Jr.	#01051701	XX ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Carmelita V Berry	#29700070	Guy & Allen Funeral Directors,Inc 2959 West 11th Avenue Gary,Indiana 46404 83007704

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 Acute Respiratory Failure	Immediate
	DUE TO (OR AS A CONSEQUENCE OF) b Metastatic Nasopharyngeal Cancer	4 Mos.
Conditions if any which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) c	
	DUE TO (OR AS A CONSEQUENCE OF) d	

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)	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	----------

CERTIFIER

29a CERTIFIER (Check only one) XX 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)
Barbara L. Fuller, M.D. FILED	0103470	4/13/00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Barbara L. Fuller, M.D. 9305 So. Calumet Ave. Ste A1 Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
AUG 17 2000 MD, MPH	APR 17 2000

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK?	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide		PETER BENJAMIN LAKE COUNTY AUDITOR		

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)
	01148

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc