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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

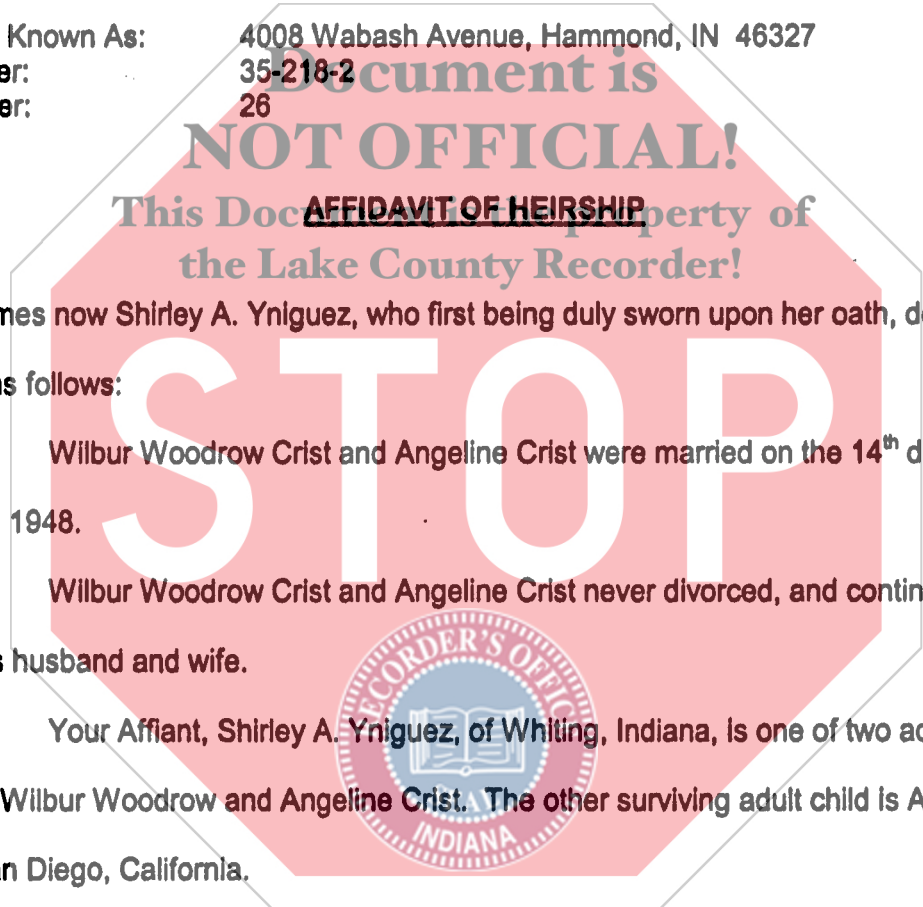
2000 062537

2000 AUG 29 AM 10:32

REC'D LAW OFFICE

Legal Description: Lot 2, and the North 5 feet of Lot 3, in Block 4, in Parkside Addition to Hammond, as per plat thereof recorded in Plat Book 16, page 25, in the Office of the Recorder of Lake County, Indiana.

Commonly Known As: 4008 Wabash Avenue, Hammond, IN 46327
Key Number: 35-218-2
Unit Number: 26



Comes now Shirley A. Yniguez, who first being duly sworn upon her oath, does allege and state as follows:

1. Wilbur Woodrow Crist and Angeline Crist were married on the 14th day of December, 1948.
2. Wilbur Woodrow Crist and Angeline Crist never divorced, and continued to live together as husband and wife.
3. Your Affiant, Shirley A. Yniguez, of Whiting, Indiana, is one of two adult surviving children of Wilbur Woodrow and Angeline Crist. The other surviving adult child is Arthur R. Crist, of San Diego, California.
4. Wilbur Woodrow Crist died on the 6th day of May, 1996.
5. All expenses of the last illness and funeral of Wilbur Woodrow Crist have been paid.
6. All State Inheritance Taxes and Federal Estate Taxes attributable to Wilbur Woodrow Crist and his estate have been paid.
7. There are no claims against the Estate of Wilbur Woodrow Crist.
8. Angeline Crist died on the 29th day of August, 1999.

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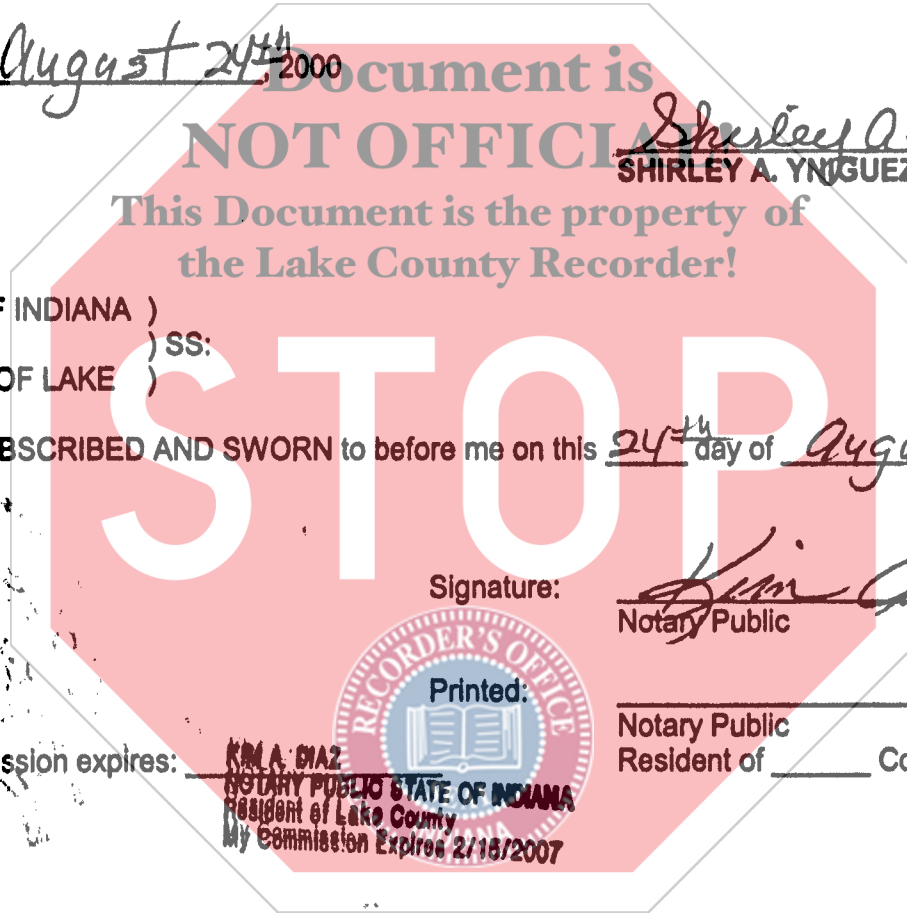
F 32531 PETER BENJAMIN
LAKE COUNTY AUDITOR
HOLD FOR FIRST AMERICAN TITLE

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K

- 9. All expenses of the last illness and funeral of Angeline Crist have been paid.
- 10. All State Inheritance Taxes and Federal Estate Taxes attributable to Angeline Crist and her estate have been paid.
- 11. There are no claims against the Estate of Angeline Crist.
- 12. This Affidavit has been made to vest Title in the above-described real estate in Shirley A. Yniguez and Arthur R. Crist.

Dated: August 24th, 2000

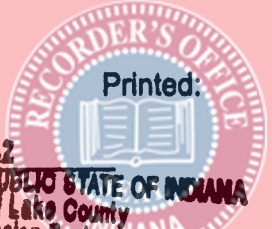


Shirley A. Yniguez
SHIRLEY A. YNIGUEZ

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SUBSCRIBED AND SWORN to before me on this 24th day of August, 2000.

Signature: [Handwritten Signature]
Notary Public



My Commission expires: KMA DIAZ
NOTARY PUBLIC STATE OF INDIANA
Resident of Lake County
My Commission Expires 2/13/2007

Notary Public
Resident of _____ County, Indiana

* 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.

Local No. 381

St. Date Issued May 13, 1996 *Franklin D. Bremenda*
Hammond Health Commissioner

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (First, Middle, Last) Wilbur W. Crist		2. SEX Male	3a. TIME OF DEATH 10:05 p.m.	3b. DATE OF DEATH (Month, Day, Year) May 6, 1996
4. SOCIAL SECURITY NUMBER 323-01-4334	5a. AGE—Last Birthday (Years) 78	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) Sept. 5, 1917
7. BIRTHPLACE (City and State or Foreign Country) Bloomington, Illinois	8. PLACE OF DEATH (Check only one. See instructions.)			
9a. WAS DECEDENT A US VETERAN? Yes	9b. YEAR LAST SERVED IN US ARMED FORCES? 1945	HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		
9c. FACILITY NAME (If not institution, give street and number) St. Margaret Mercy Hospital		9d. CITY, TOWN OR LOCATION OF DEATH Hammond	9e. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Angeline Iwinski	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Operator		12b. KIND OF BUSINESS/INDUSTRY Steel Company
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Hammond	13d. STREET AND NUMBER 4008 Wabash Avenue	
13e. ZIP CODE 46327	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (9-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Arthur Crist		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Unavailable		20a. INFORMANT'S NAME (Type/Print) Angeline Crist		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4008 Wabash Avenue, Hammond, In 46327		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) May 10, 1996 Holy Cross Cemetery		21c. LOCATION—City or Town, State Calumet City, Illinois
22a. EMBALMER'S NAME Keith D. Anthony		22b. EMBALMER'S LICENSE NO. 01011911	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b. LICENSE NUMBER (of Licenses) 01011911	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz FH 83002835 4404 Cameron, Hammond, In 46327	
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) VENTRICULAR FIBRILATION				
CONDITION AS A CONSEQUENCE OF CARDIO-PULMONARY ARREST				
CONDITION AS A CONSEQUENCE OF CARDIOVASCULAR DISEASE				
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) No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.				
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Vardaan M</i>		29b. MEDICAL LICENSE NO. AUG 22 502	29c. DATE SIGNED (Month, Day, Year) 5.7.96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type/Print) N. Sardesai, M. D. 9307 Calumet Avenue, Muncie, IN 46321				
31. HEALTH OFFICER'S SIGNATURE <i>Franklin D. Bremenda, M.D.</i>			32. DATE FILED (Month, Day, Year) MAY 08 1996	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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.		
02203				

* ATTENTION: 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.

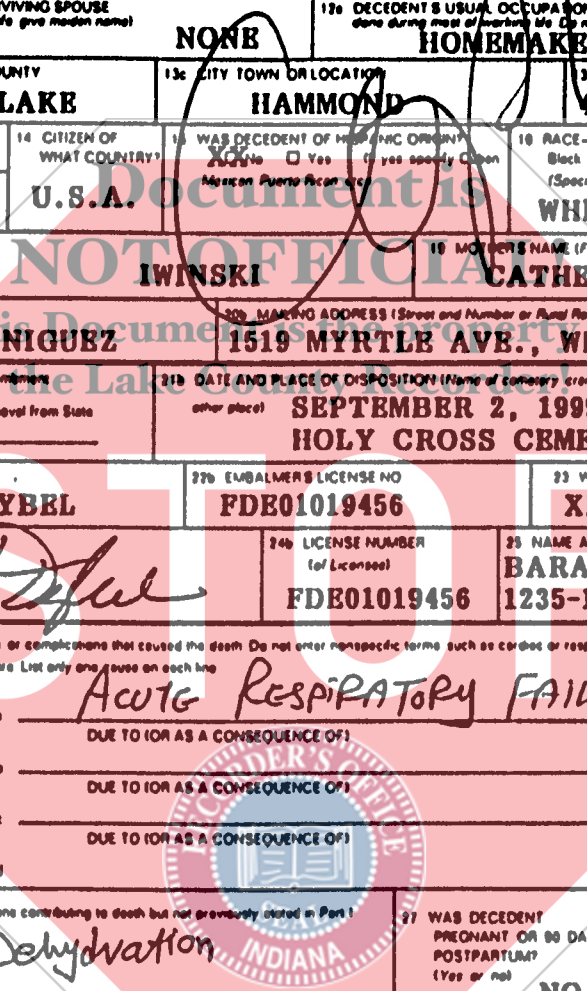
Local No. 698

S Sept. 3, 1999
Date Issued. Hammond Health Commission

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) ANGELINE CRIST		2 SEX FEMALE	3a TIME OF DEATH 12:29A	3b DATE OF DEATH (Month Day Yr) AUGUST 29, 1999	
4 SOCIAL SECURITY NUMBER 347-14-7356	5a AGE—Last Birthday (Years) 82	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) SEPT. 29, 1916	
7 BIRTHPLACE (City, State or Foreign Country) CHICAGO, ILLINOIS	8a WAS DECEDENT A U.S. VETERAN? NO				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution give street and number) ST. MARGARET MERCY HEALTHCARE CNTR. / HAMMOND		9b CITY TOWN OR LOCATION OF DEATH HAMMOND	9c COUNTY OF DEATH LAKE		
10 MARITAL STATUS 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 OWN HOME		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION HAMMOND	13d STREET AND NUMBER 4008 WABASH AVENUE		
13e ZIP CODE 46327	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (10-12) 8 College (11-4 or 5+)		18 FATHER'S NAME (First Middle Last) UNKNOWN			
19 MOTHER'S NAME (First Middle Maiden Surname) IWINSKI CATHERINE UNKNOWN		20a INFORMANT'S NAME (Type/print) MRS. SHIRLEY YNIGUEZ			
20b MARKING ADDRESS (Street and Number or Rural Route Number, City or Town, State Zip Code) 1519 MYRTLE AVE., WHITING, IN 46394		20c Relationship DAUGHTER			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) SEPTEMBER 2, 1999 HOLY CROSS CEMETERY		21c LOCATION—City or Town, State CALUMET CITY, ILL.	
22a EMBALMER'S NAME MARTIN A. DYBEL		22b EMBALMER'S LICENSE NO. FDE01019456	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Martin A. Dybel</i>		24b LICENSE NUMBER (of Licensee) FDE01019456	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394		
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) ACUTE RESPIRATORY FAILURE			3 DAYS		
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 CHF Dehydration PNEUMONIA			27 WAS DECEDENT PRENANT 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) N/A		
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date and place and due to the cause(s) as stated					
<input type="checkbox"/> 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					
<input type="checkbox"/> 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 <i>Martin A. Dybel</i>			29c MEDICAL LICENSE NO. 01034865	29d DATE SIGNED (Month Day Year) SEPT. 1, 1999	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26I (Type/print) MAHENDRA A. PATEL, M.D., 835-169TH STREET, HAMMOND, INDIANA 46324					
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Mahendra A. Patel M.D.</i>			32 DATE FIED (Month Day Year) September 3, 1999		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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.			



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER