STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 062537

2000 AUG 29 AM 10:32

MICHAEL B. BROWN CARTER
RECORDER

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

AFFIDAVIT OF HEIRSHIP

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.

FILED
AUG 29 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

F 32531
HOLD FOR FIRST AMERICAN TITLE

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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: Kim A. Diaz
Notary Public

Printed: _____
Notary Public
Resident of _____ County, Indiana

My Commission expires: KIM A. DIAZ NOTARY PUBLIC STATE OF INDIANA Resident of Lake County My Commission Expires 2/16/2007

This instrument was prepared by Lisa K. Misner, #16139-45
CASALE, SKOZEN, WOODWARD & BULS, LLP
5201 Fountain Drive, Suite A, Crown Point, Indiana 46307; (219) 736-2163

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

May 3, 1996 Date Issued — Hammond Health Commission

* 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. 381

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

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)
Wilbur W.	Crist	Male	10:05 PM	May 6, 1996

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)
323-01-4334	78			Sept. 5, 1917	Bloomington, Illinois

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)
Yes	1945	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 Hospital	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	Angeline Iwinski	Operator	Steel Company

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hammond	4008 Wabash Avenue

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (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+)
46327	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Arthur Crist	Edith Unavailable

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
Angeline Crist	4008 Wabash Avenue, Hammond, In 46327	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
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 10, 1996 Holy Cross Cemetery	Calumet City, Illinois

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Keith D. Anthony	01011911	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Keith D Anthony	01011911	Anthony & Dziadowicz FH 83002835 4404 Cameron, Hammond, In 46327

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. VENTRICULAR FIBRILLATION	
	DUE TO (OR AS A CONSEQUENCE OF) b. CARDIO-PULMONARY ARREST	
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) c. CORONARY ARTERY DISEASE.	
	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	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)
N. Sardesai, M. D.	AUG 29 2000 29503	5.7.96

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	
N. Sardesai, M. D. 9307 Calumet Avenue, Munster, In 46321	May 7, 1996

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Granthan D. Bermuda, M.D.	MAY 08 1996

PETER BENJAMIN LOMAX, AUDITOR LAKE COUNTY, IND.

FILED

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.

02203

* 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. 698

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

Sept. 3, 1999 — Date Issued — Franklin D. Brenneke — Hammond Health Commission

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)
ANGELINE	CRIST	FEMALE	12:29A M	AUGUST 29, 1999

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)
347-14-7356	82			SEPT. 29, 1916	CHICAGO, 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
ST. MARGARET MERCY HEALTHCARE CNTR.	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
WIDOWED	NONE	HOMEMAKER	OWN HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	4008 WABASH AVENUE

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)	
46327	XX No ☐ Yes	XX No ☐ Yes	U.S.A.	XX No ☐ Yes	WHITE	Elementary/Secondary (0-12) 8	College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
UNKNOWN IWINSKI	CATHERINE UNKNOWN

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
MRS. SHIRLEY YNIGUEZ	1519 MYRTLE AVE., WHITING, IN 46394	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
XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	SEPTEMBER 2, 1999 HOLY CROSS CEMETERY	CALUMET CITY, ILL.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
MARTIN A. DYBEL	FDE01019456	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Martin A. Dybel	FDE01019456	BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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	3 DAYS
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: CHF, PNEUMONIA, Dehydration

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	N/A

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)
[signature]	01034865	SEPT. 1, 1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29) (Type/Print)
MAHENDRA A. PATEL, M.D., 835-169TH STREET, HAMMOND, INDIANA 46324

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Franklin D. Brenneke M.D.	September 3, 1999

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