

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2000 068111

2000 SEP 19 AM 10:55

MORRIS W. CARTER  
RECORDER

AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Dorothy Boffo, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Everett A. Boffo died (without leaving a will) (~~xxxxxx~~) on April 14, 2000 at 1502 N. Woodlawn Place, Griffith, IN

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 1 in Ridge Gardens Addition to the Town of Griffith, as per plat thereof, recorded in Plat Book 35, Page 20, in the Office of the Recorder of Lake County, Indiana.

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.

PETER BENJAMIN  
LAKE COUNTY AUDITOR

COMMUNITY TITLE COMPANY  
FILE NO 20044mv

Dorothy Boffo  
Dorothy Boffo

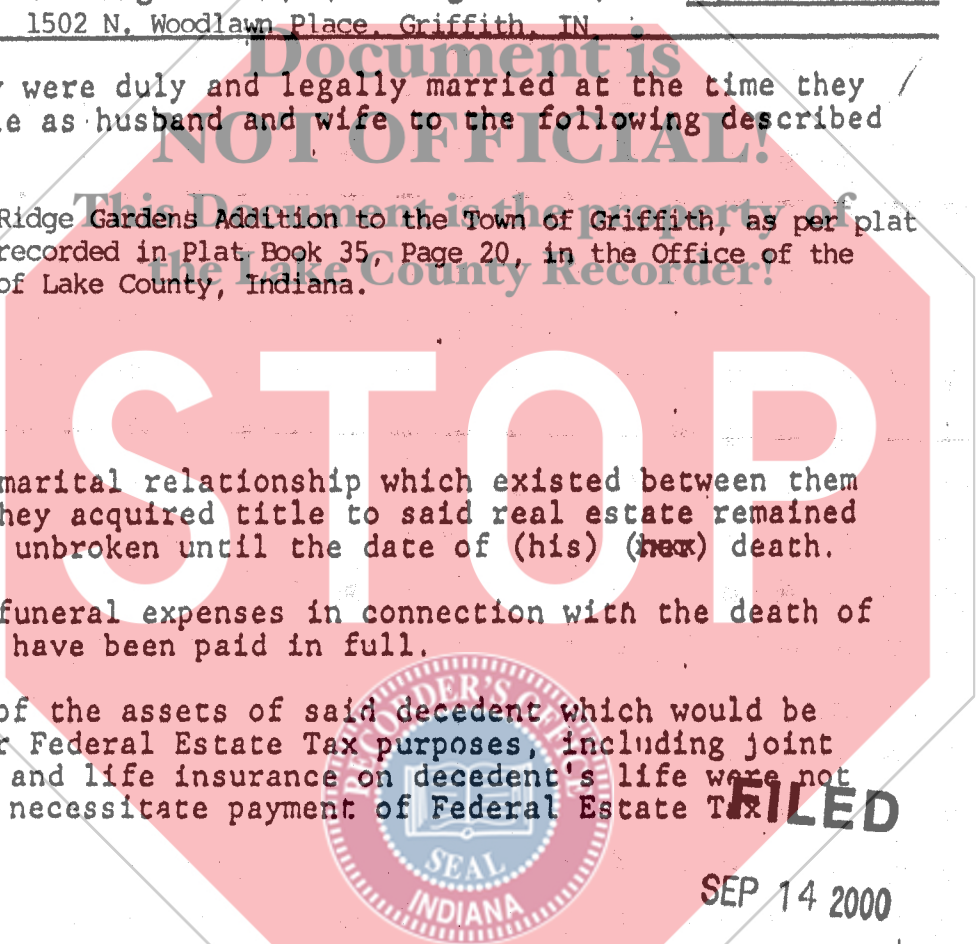
Subscribed and sworn to before me, a Notary Public, this 8th day of September, 2000.

Amy M. Hood  
Notary Public

Prepared By: Dorothy Boffo

Official Seal  
Amy M. Hood  
Notary Public  
State of Indiana  
My Commission Expires 8-13-06  
00898

cm  
llh



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\* 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

State No. ....

Local No. .... 0945-00

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>EVERETT A. BOFFO</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>8:00 P M</b>	3b DATE OF DEATH (Month, Day, Yr.) <b>April 14, 2000</b>	
4 *SOCIAL SECURITY NUMBER <b>323-05-1619</b>	5a AGE—Last Birthday (Years) <b>90</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) <b>October 7, 1909</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Thurber, Texas</b>	8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a FACILITY NAME (If not mentioned, give street and number) <b>1502 N. Woodlawn Place</b>		9b CITY, TOWN, OR LOCATION OF DEATH <b>Griffith</b>	9c COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Dorothy Mamala</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Fabricating Planner</b>		12b KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN, OR LOCATION <b>Griffith</b>	13d STREET AND NUMBER <b>1502 N. Woodlawn Place</b>		
13e ZIP CODE <b>46319</b>	14 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th</b>	17a ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
18 FATHER'S NAME (First, Middle, Last) <b>Matthew Boffo</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Theresa N/A</b>			
20a INFORMANT'S NAME (Type/Print) <b>Dorothy Boffo</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1502 N. Woodlawn PL, Griffith, In. 46319</b>		20c Relationship <b>Wife</b>	
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) <b>April 17, 2000 Calumet Park Cemetery</b>		21c LOCATION—City or Town, State <b>Merrillville, Indiana</b>	
22a EMBALMER'S NAME <b>Dean G. Wagner</b>		22b EMBALMER'S LICENSE NO. <b>8800057</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of license) <b>8800057</b>	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN. 46324</b>		
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 <b>severe acute stenosis</b>			
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b <b>congestive heart failure</b>			
c		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? <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? <b>NO</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>N/A</b>		
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>Peter Benjamin</i> M.D. <b>PETER BENJAMIN</b>			
29c MEDICAL LICENSE NO. <b>0104423</b>		29d DATE OF EXPIRATION (Month, Day, Year) <b>SEP 14 2000</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Tarek Kudaimi, M.D. 800 MacArthur Blvd, Suite 12A., Munster, IN. 46321</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams</i> M.D.		32 DATE FILED (Month, Day, Year) <b>April 18, 2000</b>			
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)	THIS DEATH IS BEING FILED AS A CAUSE OF DEATH AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. <b>APR 18 2000 0899</b>
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34b LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34c DATE PRONOUNCED DEAD (Month, Day, Year)		34d MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>2</b>			