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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

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2000 SEP 21 PM 4: 06

MORRIS W. CARTER  
RECORDER

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

A F F I D A V I T

MARY S. WALSH, being first duly sworn, states:

1. She is a resident of Lake County, Indiana.
2. Affiant states that she is the surviving spouse of Thomas O. Walsh, who died a resident of Lake County, Indiana, on May 11, 1999. A certified copy of his death certificate is attached hereto and incorporated herein.
3. At the time of his death, Thomas O. Walsh and Mary S. Walsh, husband and wife, were the owners of the following described real estate located in Lake County, Indiana:  
  
Lot 54 in Brookwood, a subdivision in the Town of Merrillville, Lake County, Indiana, commonly known and described as 6336 Garfield Street, Merrillville, Indiana 46410. Unit 8, Key No. 15-0199-0004.
4. At the time of his death, Thomas O. Walsh and Mary S. Walsh were not divorced and were living together as husband and wife.
5. Affiant further states that no federal estate tax is due from the Estate of Thomas O. Walsh.
6. This Affidavit is made by the undersigned to confirm that ownership in the above-described real estate is now vested in the undersigned, Mary S. Walsh, and to induce the Auditor of Lake County to reflect the correct ownership of such real estate on said Auditor's records.

**FILED**

SEP 2 2000

PETER BENJAMIN  
LAKE COUNTY AUDITOR

01344

13<sup>00</sup>/<sub>Ac</sub>  
55991

25 X 10

Dated September 14, 2000.

Mary S. Walsh  
MARY S. WALSH

STATE OF INDIANA )  
COUNTY OF LAKE )

Document is  
NOT OFFICIAL!

Before me, the undersigned, a Notary Public in and for said County and State, this 14th day of September, 2000, personally appeared Mary S. Walsh, who, being duly sworn, stated that the facts contained in the foregoing Affidavit are true and correct and acknowledged the execution of the above and foregoing Affidavit.

WITNESS my hand and Notarial Seal.

Margaret Perz  
MARGARET PERZ, Notary Public

MY COMMISSION EXPIRES:

September 12, 2007

Resident of Lake County



This instrument prepared by Edward L. Burke, Attorney At Law, 8585 Broadway, Suite 610, Merrillville, Indiana 46410

This Document Not Valid Unless  
Stamped on Reverse Side and  
Embossed with Raised Seal of  
Porter County

PORTER COUNTY  
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT  
155 Indiana Ave.  
Suite 104  
Valparaiso, IN 46383

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) <b>THOMAS O WALSH</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>11:00 PM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>May 11, 1999</b>
4. SOCIAL SECURITY NUMBER <b>316-30-5406</b>	5a. AGE - Last Birthday (Years) <b>67</b>	5b. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	5c. UNDER 1 DAY Hours <b>0</b> Minutes <b>0</b>	6. DATE OF BIRTH (Mo., Day, Yr.) <b>December 27, 1931</b>
7. BIRTH PLACE (City and State or Foreign Country) <b>TERRE HAUTE Indiana</b>	8. PLACE OF DEATH (Check only one - See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	9b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>n/avail</b>	9c. CITY, TOWN, OR LOCATION OF DEATH <b>Valparaiso</b>		
10. FACILITY NAME (If not institution, give street and number) <b>Porter Memorial Hospital</b>		9d. COUNTY OF DEATH <b>Porter</b>		
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>MARY STEINEMANN</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>PAST PRESIDENT</b>	12b. KIND OF BUSINESS/INDUSTRY <b>WALSH AND KELLY INC</b>	
13a. RESIDENCE - STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>MERRILLVILLE</b>	13d. STREET AND NUMBER <b>6336 GARFIELD STREET</b>	
13e. ZIP CODE <b>46410</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</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) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 6+) <b>4</b>		18. FATHER'S NAME (First, Middle, Last) <b>JOHN R WALSH</b>		
19. MOTHER'S NAME (First, Middle, Last) <b>ELIZABETH O'HARA</b>		20. INFORMANT'S NAME (Type/Print) <b>MARY S WALSH</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6336 GARFIELD STREET, MERRILLVILLE, IN</b>		20c. Relationship <b>WIFE</b>		
21a. METHOD OF DISPOSITION <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) <b>May 15, 1999 ST. PAUL CEMETERY</b>		21c. LOCATION - City or Town, State <b>VALPARAISO, Indiana</b>
22a. EMBALMER'S NAME <b>Gordon L. Jones</b>		22b. EMBALMER'S LICENSE NO. <b>01010711</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Reverend P. Burns</i>		24b. LICENSE NUMBER (of Licensee) <b>FD1013890</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns Funeral Home 10101 Broadway, Crown Point, Indiana 46307-8801</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 cause or condition resulting in death) <b>Cardio respiratory failure</b> <b>no rules</b>				
DUE TO (OR AS A CONSEQUENCE OF): <b>myocardia</b> <b>Days</b>				
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				
<b>Multiple Sclerosis</b>				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
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>Lallari</i>		29c. MEDICAL LICENSE NO. <b>01036781</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-20-99</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28)(Type/Print) <b>DR. SURIA NALLARI 1101 E. GLENDALE BLVD., VALPARAISO, IN 46383</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Babcock MD</i>				32. DATE FILED (Month, Day, Year) <b>May 20, 1999</b>
33. MANNER OF DEATH <b>V</b> <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) <b>SEP 2 2000</b>	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) <b>01:25</b>
34d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) <b>PETER BENJAMIN LAKE COUNTY AUDITOR</b>		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
35. DATE PRONOUNCED DEAD (Month, Day, Year) <b>May 11, 1999</b>		36. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.		