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STATE OF INDIANA)
LAKE COUNTY)
FILED FOR RECORD

2000 071222 2000 SEP 29 AM 10:53

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Eugenia Marie Miller, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Carl H miller died (without leaving a will) (leaving a will) on July 1 19 2000 at St. mary Medical Center

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

LOTS 22 AND 23 IN BLOCK 12 IN FIRST SUBDIVISION OF EAST GARY, IN THE CITY OF LAKE STATION, AS PER PLAT THEREOF, RECORDED DECEMBER 12, 1907 IN PLAT BOOK 7 PAGE 9, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

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SEP 2 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

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.

COMMUNITY TITLE COMPANY
FILE NO 20089

Further affiant sayeth not.

Eugenia M. Miller
EUGENIA MARIE MILLER

Subscribed and sworn to before me, a Notary Public, this 19th day of SEPTEMBER, 2000.

Tracie A Kraszyk
Notary Public

TRACIE A. KRASZYK
Notary Public, State of Indiana
County of Porter
My Commission Expires Jan. 12, 2008

11.00 E.P.

01718

TOTAL P.01

cm

25x

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* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 1500-00

24035

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED-NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
CARL H. MILLER SR.	Male	2:35PM	July 1, 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)
317-20-8558	73			September 28, 1926	Three Rivers, Michigan

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	1947	HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

DECEDENT

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. MARY MEDICAL CENTER	Hobart	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	Jean M. Urdesu	Businessman	Self Employed

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Lake Station	2315 Vermillion St.

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+)
46405	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	Caucasian	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Herman Miller	Freida Holtfoth

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
Jean M. Miller	2315 Vermillion St., Lake Station, IN 46405	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
☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	July 6, 2000 CALVARY CREMATORY	PORTAGE, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
JAMES J. KRAUSE	FD01006463	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Charles D. Scherer, Jr.	FDO1006049	FH19300009 Rees Funeral Home, Brady Chapel 3781 Central Avenue, Lake Station, IN 46405

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. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF)	Several
	b. Type 2 Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF)	Years
Conditions if any which gave rise to the immediate cause stating the underlying cause last	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d.	

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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

SEP 2000

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.

REBER BENJAMIN
LAKE COUNTY AUDITOR

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
T. G. Goodwin M.D.	01019939	7/6/00

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)

THOMAS G. GOODWIN MD, 6111 HARRISON STREET, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE Alexander Williams MD

THIS [illegible] 32. DATE FILED (Month Day Year) AND CO[illegible] OF DEATH

JUL 06 2000

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.

Alexander Williams MD
LAKE COUNTY HEALTH COMMISSIONER

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

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