

2

FA# F33128

LEGAL DESCRIPTION:

The South 10 feet of Lot 31 and all of Lot 32 in Block 4 in Calumet Boulevard Addition to Hammond, as shown thereon, recorded in Plat Book 18, page 31, in the Office of the Recorder of Lake County, Indiana.

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

OCT 16 AM 10:32  
MORRIS W. CARTER  
RECORDER



First American Title  
Insurance Company

PROPERTY ADDRESS:

7140 Tapper Avenue, Hammond, IN 46324

**ESTATE AFFIDAVIT**

RICHARD R. RARICK, Affiant, states that:

1. ROSEMARIE RARICK, deceased, died on the 23<sup>rd</sup> day August of 2000

2. Affiant is:  the surviving spouse of the deceased,  
 the Personal Representative/Executor-trix of the estate of the deceased;

+ son of the deceased  
3. The deceased died:  leaving a will which has been probated;  
 leaving a will which has not been probated;  
 leaving no will;

4. The deceased and Affiant were married on the \_\_\_\_\_ day of \_\_\_\_\_; and were never divorced.  
(This item applies only to the surviving spouse.)

5.  All expenses of the last illness and funeral of the deceased have been paid;

6.  All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7.  There have been no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

10/10/00  
Date

Signature of Affiant

RICHARD R. RARICK  
Printed Name of Affiant

State of Indiana, County of LAKE

Subscribed and sworn to before me, this 10TH day of OCTOBER, 2000.

KIM A. DIAZ  
Printed Name of Notary

Signature of Notary

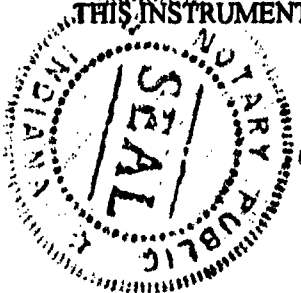
My Commission expires: 2/15/07

My County of Residence is: LAKE

FILED

THIS INSTRUMENT WAS PREPARED BY: RICHARD RARICK

OCT 16 2000 01259



PETER BENJAMIN  
LAKE COUNTY AUDITOR

HOLD FOR FIRST AMERICAN TITLE

1200  
E.P.  
FA

\* 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 AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

*Franklin S. Prevede M.D.*

Local No. 647

Date Issued Sept 28 1998 Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Rosemarie Rarick</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>7:30 AM</b>	3b DATE OF DEATH (Month Day Yr) <b>August 23, 1998</b>
4 SOCIAL SECURITY NUMBER <b>306-28-2281</b>	5a AGE—Last Birthday (Year) <b>70</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>February 18, 1928</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Council Bluffs, Iowa</b>	8a WAS DECEDENT A US VETERAN? <b>No</b>			
8b YEAR LAST SERVED IN US ARMED FORCES? <b>None</b>	8c PLACE OF DEATH (Check only one. See instructions) <b>HOSPITAL</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Home of Son			
9a FACILITY NAME (If not institution, give street and number) <b>933-177th Place</b>		9b CITY TOWN OR LOCATION OF DEATH <b>Hammond</b>		9c COUNTY OF DEATH <b>Lake</b>
10 MARITAL STATUS (Specify) <b>Widowed</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>None</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>		12b KIND OF BUSINESS/INDUSTRY <b>Own Home</b>
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Hammond</b>	13d STREET AND NUMBER <b>7140 Tepper Ave.,</b>	
13e ZIP CODE <b>46324</b>	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input 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 (8-12) <input type="checkbox"/> College (1-4 or 5+) <b>12</b>		18 FATHER'S NAME (First Middle Last) <b>Not Available</b>		
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Not Available</b>		20a INFORMANT'S NAME (Type/Print) <b>Richard Rarick</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>933-177th Place, Hammond, IN 46324</b>		20c Relationship <b>Son</b>		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" 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>August 26, 1998 Heritage Crematory</b>		21c LOCATION—City or Town, State <b>Portage, IN</b>
22a EMBALMER'S NAME <b>Henry J. Blake</b>		22b EMBALMER'S LICENSE NO. <b>FD01019406</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Eddie B. Luff</i>		24b LICENSE NUMBER (of Licensee) <b>FD01000857</b>		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>LeHayne Funeral Home, Inc., FH19400005 6955 Southeastern 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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Bronchopneumonia</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				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <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) <b>NO</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>Franklin S. Prevede M.D.</i>			29c MEDICAL LICENSE NO. <b>33507</b>	29d DATE SIGNED (Month Day Year) <b>August 24, 1998</b>
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 28) (Type/Print) <b>Howard M. Mishoulem, M.D., 1630-45th, Munster, IN 46321</b>				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Prevede M.D.</i>				32 DATE FIED (Month Day Year) <b>August 25, 1998</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"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED		
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.				