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State of Indiana
County of Lake

2002 013161

2002 01 24 57

AFFIDAVIT OF SURVIVORSHIP

Comes now Marie L. Kainrath and upon being duly sworn does attest and say:

- 1. That the affiant is the spouse of Robert A. Kainrath, , deceased.
- 2. That Marie L. Kainrath and Robert A. Kainrath were the owners as Tenants by the entirety of real property located in Lake County Indiana, more particularly described as:

Lot 115 in Crestwood Park addition to the City of Hobart as recorded in Plat Book 31, Page 8 in the office of the Recorder of Lake County.

3. That Robert A. Kainrath and Marie L. Kainrath acquired the property during the term of their marriage.

4. That Marie L. Kainrath and Robert A. Kainrath remained married until the death of Robert A. Kainrath on the 20th of September, 2001.

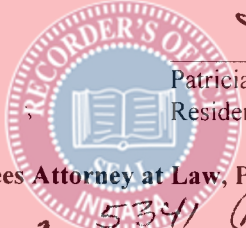
5. That Marie L. Kainrath became the fee simple owner of the property at the death of Robert A. Kainrath.

I affirm under penalties for perjury that the foregoing statements are true.

Marie L. Kainrath
Marie L. Kainrath

STATE OF INDIANA
COUNTY OF LAKE

Before me a Notary Public appeared Marie L. Kainrath and she did sign this document in my presence on this 24 day of January, 2002



Patricia A. Rees

Patricia A. Rees, Notary Public
Resident of Lake County, Comm. Exp. 7-5-02

FILED

FEB 1 2002

This Instrument prepared by Patricia A. Rees Attorney at Law, P.O. Box 488, Hobart, In 46342

Central Ave

PETER BENJAMIN
LAKE COUNTY AUDITOR

000027

*11-
N. H.
6781*

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue 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. 2160-01

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

393934
/PE/PRINT
IN
PERMANENT
LACK INK

1 DECEASED—NAME (First Middle, Last) ROBERT A. Kainrath				2 SEX Male	3a TIME OF DEATH 2:48p M	3b DATE OF DEATH (Month, Day, Year) September 20, 2001
4 *SOCIAL SECURITY NUMBER 311 40 8621		5a AGE—Last Birthday (Years) 61	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) March 31, 1940	7 BIRTHPLACE (City and State or Foreign Country) Gary, IN
8a WAS DECEDENT A U.S. VETERAN? yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 18-2-1960		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) 318 Crestwood Dr.				9c CITY, TOWN OR LOCATION OF DEATH Hobart IN		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) MARIE L. Wozniak		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Mail Carrier		12b KIND OF BUSINESS/INDUSTRY Government Postal
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hobart IN		13d STREET AND NUMBER 318 Crestwood Dr
13e ZIP CODE 46342	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) white	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____
18 FATHER'S NAME (First, Middle, Last) Leo Kainrath				19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary Suhanik		
20a INFORMANT'S NAME (Type/Print) Marie Kainrath			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Crestwood Dr. Hobart, IN 46342		20c Relationship Wife	
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) September 24, 2001 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, IN 46410	
22a EMBALMER'S NAME Anthony S. Rendina Jr			22b EMBALMER'S LICENSE NO. FD01010402		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr</i>			24b LICENSE NUMBER (of Licensee) FD01010402		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home FH83007819 5100 Cleveland St Gary, IN 46408	
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) Conditions if any, which gave rise to the immediate cause, stating the underlying cause last a _____ DUE TO (OR AS A CONSEQUENCE OF) b _____ DUE TO (OR AS A CONSEQUENCE OF) c _____ DUE TO (OR AS A CONSEQUENCE OF) d _____ PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I						Approximate Interval Between Onset and Death
			27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no		28a WAS AN AUTOPSY PERFORMED? no 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>Peter Benjamin</i> PETER BENJAMIN LAKE COUNTY AUDITOR			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Ray E. Drasga, MD 8127 Merrillville rd Merrillville, IN						29d DATE SIGNED (Month, Day, Year) FEB 1 2002
31 HEALTH OFFICER'S SIGNATURE <i>Susan J. But...</i>						THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. <i>September 27, 2001</i>
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED SEP 27 2001	
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. 000028				

DECEDENT

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FORMANT

POSITION

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