


TICOR TITLE INSURANCE

2002 APR 11 31

2002 MAY 01 8:47

STATE OF INDIANA)
COUNTY OF LAKE) SS:

RECORDED
INDEXED

FERN A. BUCHMEIER, being first duly sworn upon oath, deposes and says:

1. That WALLACE A. BUCHMEIER died on June 8, 1999 at St. Margaret's Hospital.

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

THAT PART LYING NORTHWESTERLY OF THE CENTERLINE OF THE BULL RUN DITCH OF THE FOLLOWING DESCRIBED PARCEL OF LAND: THE WEST HALF OF THE SOUTHWEST QUARTER OF THE NORTHWEST QUARTER OF SECTION 31, TOWNSHIP 35 NORTH, RANGE 9 WEST OF THE SECOND PRINCIPAL MERIDIAN, IN LAKE COUNTY, INDIANA EXCEPTING THEREFROM THE THE NORTH 99.1 FEET OF THE SAID WEST HALF. Key # 11-24-6 (9)

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.

Subscribed and sworn to before me, a Notary Public, this 26TH day of APRIL, 192002



Gloria Miller
Notary Public
GLORIA MILLER

My Commission expires:

10-29-08 9-24-06

County of Residence:
LAKE

This Instrument prepared by FERN A. BUCHMEIER

FILED

MAY 01 2002

Peter Benjamin
LAKE COUNTY AUDITOR

000027



Gloria Miller
Lake County
My Commission Expires
October 29, 2008



Patricia R. Smith
Notary Public, State of Indiana
Lake County
My Commission Expires 10/29/08

TOTAL P. 01

TICOR TITLE INSURANCE H.O. 920051727
Crown Point, Indiana

* 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

Local No. 1378-99

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

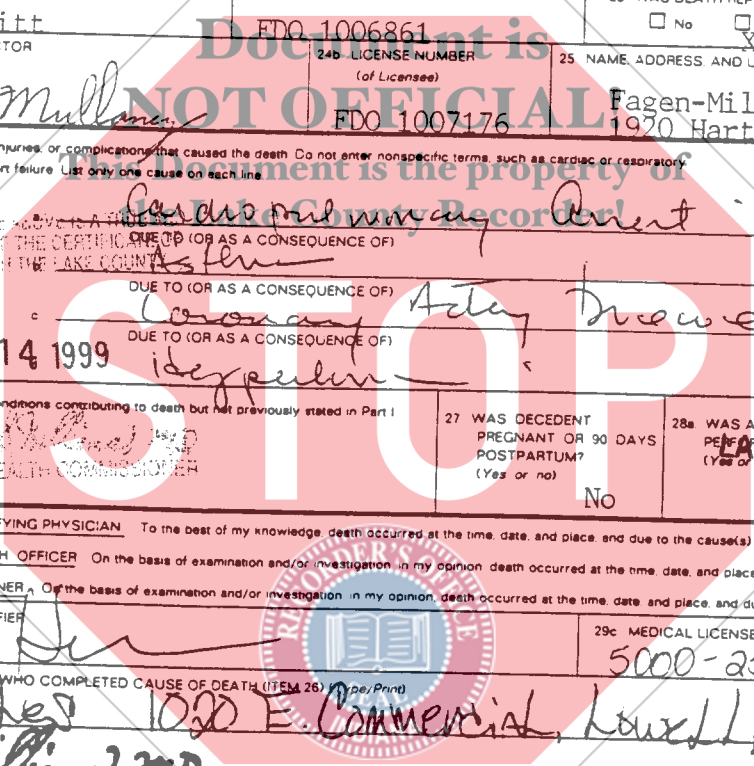
CAUSE OF DEATH

WIS 92063172
CAUSE OF DEATH
HOUR TITLE INSURANCE
2050-45TH AVE
HIGHLAND, IN 46109

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <u>Wallace A. Buchmeier</u>		2 SEX <u>Male</u>	3a. TIME OF DEATH <u>9:08 A M</u>	3b. DATE OF DEATH (Month, Day, Yr) <u>June 8, 1999</u>	
4. *SOCIAL SECURITY NUMBER <u>307-42-5185</u>	5a. AGE—Last Birthday (Years) <u>69</u>	5b. UNDER 1 YEAR Months Days <u> </u>	5c. UNDER 1 DAY Hours Minutes <u> </u>	6. DATE OF BIRTH (Mo, Day, Yr) <u>April 9, 1930</u>	
7a. WAS DECEDENT A U.S. VETERAN? <u>No</u>	7b. YEAR LAST SERVED IN U.S. ARMED FORCES? <u>N/A</u>	7. BIRTHPLACE (City and State or Foreign Country) <u>Yellowhead Twp, Illinois</u>			
8a. FACILITY NAME (If not institution, give street and number) <u>St Margaret Mercy Hospital-South</u>		8b. CITY, TOWN OR LOCATION OF DEATH <u>Dyer</u>		8c. COUNTY OF DEATH <u>Lake</u>	
9a. MARITAL STATUS (Specify) <u>Married</u>	9b. SURVIVING SPOUSE (If wife, give maiden name) <u>Fern L. Neitzel</u>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Self Employed</u>		12b. KIND OF BUSINESS/INDUSTRY <u>Farming</u>	
13a. RESIDENCE—STATE <u>Indiana</u>	13b. COUNTY <u>Lake</u>	13c. CITY, TOWN OR LOCATION <u>Dyer</u>	13d. STREET AND NUMBER <u>13650 W. 101st Ave</u>		
13e. ZIP CODE <u>46311</u>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	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) <u>White</u>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (11-4 or 5 +) <u> </u>		18. FATHER'S NAME (First, Middle, Last) <u>Alvin Buchmeier Sr</u>			
19. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hilda Koennecke</u>		20a. INFORMANT'S NAME (Type/Print) <u>Fern L. Buchmeier</u>			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>13650 W. 101st Ave Dyer, Indiana 46311</u>		20c. Relationship <u>Wife</u>			
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) <u> </u>		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>June 11, 1999</u> <u>Zion United Church of Christ Cemetery</u>		21c. LOCATION—City or Town, State <u>Dyer, Indiana</u>	
22a. EMBALMER'S NAME <u>Scott J. Prewitt</u>		22b. EMBALMER'S LICENSE NO. <u>FD0 1006861</u>	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <u>Edward E. Mullane</u>		24b. LICENSE NUMBER (of Licensee) <u>FD0 1007176</u>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <u>Fagen-Miller Funeral Homes Inc</u> <u>1920 Hart St Dyer, Indiana 46311</u> <u>FH830015C</u>		
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. <u>Cardiovascular arrest</u> <u>Asystole</u> <u>Coronary Artery Disease</u> <u>Myocardial Infarction</u> <u>Ischemic</u>					
IMMEDIATE CAUSE (Final disease or condition) <u> </u> DUE TO (OR AS A CONSEQUENCE OF) <u> </u> resulting in death <u> </u> DUE TO (OR AS A CONSEQUENCE OF) <u> </u> DUE TO (OR AS A CONSEQUENCE OF) <u> </u> Conditions: if any, state the rise to the immediate cause, stating the underlying cause last. <u> </u> DUE TO (OR AS A CONSEQUENCE OF) <u> </u> <u> </u> DUE TO (OR AS A CONSEQUENCE OF) <u> </u>					
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I <u> </u>					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <u>No</u>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <u>No</u>		28b. FINDINGS OF DEATH? (Yes or no) <u>NO</u>	
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 <u> </u>			
29c. MEDICAL LICENSE NO. <u>5000-2521</u>		29d. DATE SIGNED (Month, Day, Year) <u>06-11-99</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <u>Dr. Lynes 1030 E. Commercial, Lowell, IN</u>					
31. HEALTH OFFICER'S SIGNATURE <u>Alexander Wilkins MD</u>				32. DATE FILED (Month, Day, Year) <u>6/19/99</u>	
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) <u> </u>	34b. TIME OF INJURY <u> </u>	34c. INJURY AT WORK? (Yes or no) <u> </u>	34d. DESCRIBE HOW INJURY OCCURRED <u>000028</u>
34e. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) <u> </u>		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u> </u>			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) <u> </u>		34h. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes, specify driver, passenger, pedestrian, etc. <u> </u>			



FILED

MAY 01 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR