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STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

2002 116230

2002 DEC 16 AM 9:48
RECORDER

AFFIDAVIT

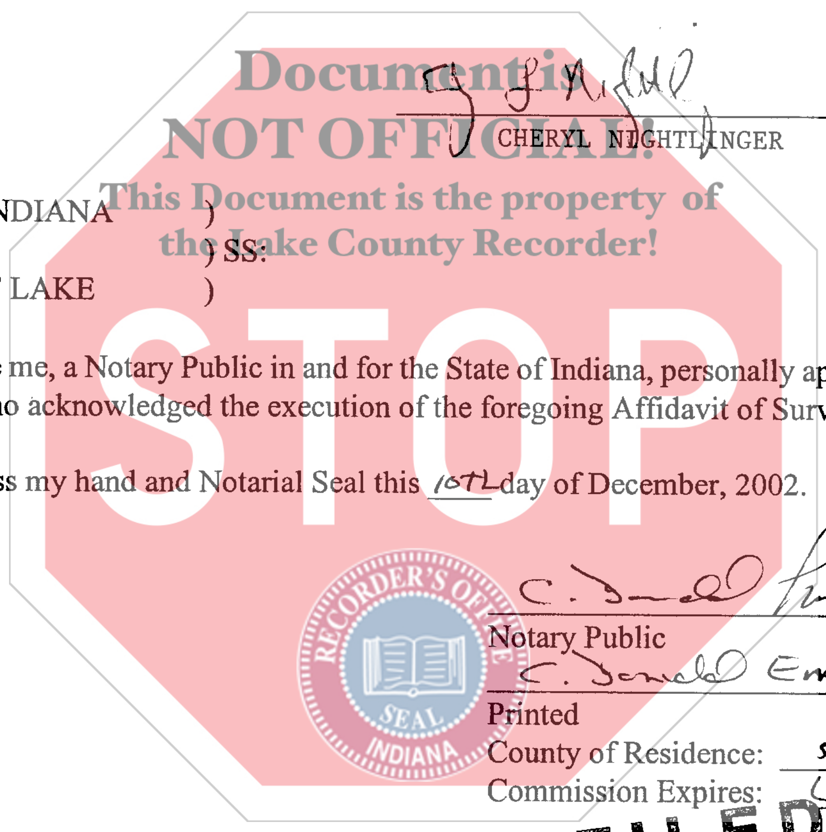
CHERYL NIGHTLINGER, being duly sworn upon her oath, and states as follows:

1. DONNA J. GEHRKE died on the 9th day of December, 2001

2. The gross value of the estate of the decedent, DONNA J. GEHRKE, as determined for the purpose of Federal Estate Taxes, was less than the value required for the filing, and the decedent's estate was not subject to Federal Estate Tax.

3. The decedent's estate was subject to Indiana Inheritance Taxes which were paid.

FURTHER YOUR AFFIANT SAYETH NOT.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STOP

CHERYL NIGHTLINGER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, a Notary Public in and for the State of Indiana, personally appeared CHERYL NIGHTLINGER who acknowledged the execution of the foregoing Affidavit of Survivorship.

Witness my hand and Notarial Seal this 10th day of December, 2002.

C. Donald Emery III
Notary Public
C. Donald Emery III
Printed
County of Residence: 5/5/07
Commission Expires: Lake

This instrument prepared by: C. Donald Emery, III, EMERY CLEMENT & SCHMIDT, P.C., 370 West 80th Place, Merrillville, Indiana 46410.

FILED
DEC 13 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR
001032

Chicago Title Insurance Company

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.

Local No. 3015-01

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Donna J. Gehrke
2. SEX: Female
3a. TIME OF DEATH: 1:25 A M
3b. DATE OF DEATH (Month, Day, Yr): December 9, 2001
4. SOCIAL SECURITY NUMBER: 305-28-6887
5a. AGE—Last Birthday (Years): 72
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Dec. 1, 1929
7. BIRTHPLACE (City and State or Foreign Country): (unavailable), Indiana
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Anthony Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widow
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Griffith
13d. STREET AND NUMBER: 603 N. Raymond St.
13e. ZIP CODE: 46319
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+):

PARENTS

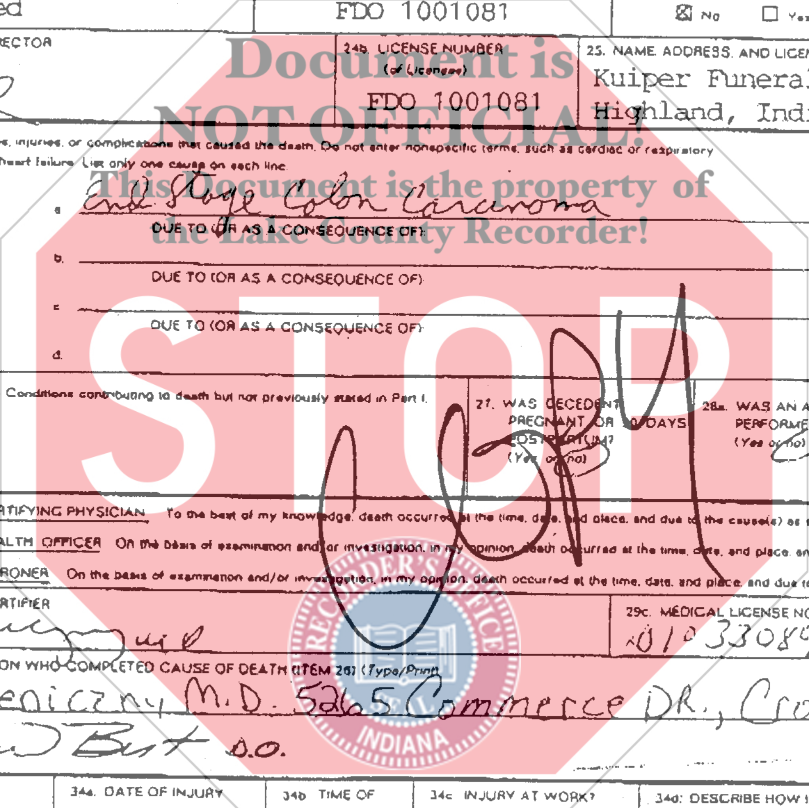
18. FATHER'S NAME (First, Middle, Last): Joseph Oscar Ludders
19. MOTHER'S NAME (First, Middle, Maiden Surname): Velma Davis

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Cheryl Nightlinger
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9200 Mallard Ln., St. John, Indiana 46373
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 12, 2001 Chapel Lawn Cemetery
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Ronald A. Reed
22b. EMBALMER'S LICENSE NO.: FDO 1001081
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Ronald A. Reed
24b. LICENSE NUMBER (of Licensee): FDO 1001081
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home, 9039 Kleinman Rd. Highland, Indiana 46322 FH 19900008



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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. End Stage Colon Carcinoma — Approximate Interval Between Onset and Death: 2 months
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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 30 DAYS POSTPARTUM? (Yes or no): no
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): no
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): no

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Elizabeth Przeniczny MD
29c. MEDICAL LICENSE NO.: 01033084
29d. DATE SIGNED (Month, Day, Year): 12-10-2001
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Elizabeth Przeniczny M.D. 5265 Commerce DR., Crown Point, IN 46307

HEALTH OFFICER

31. HEALTH OFFICERS SIGNATURE: Susan W Bert D.O.
32. DATE FILED (Month, Day, Year): December 12, 2001

33. MANNER OF DEATH: ☐ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. TIME OF INJURY:
34c. INJURY AT WORK? (Yes or no):
34d. DESCRIBE HOW INJURY OCCURRED:
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.

SDH06-004 State Form 10110 (R5/1-99)