33142BK

2

** TOTAL PAGE.02 **

CHICAGO TITLE INSURANCE COMPANY

2003 107047

2003 OCT -7 10:01

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Margaret M Walsh, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Thomas J. Walsh died (without leaving a will) (leaving a will) on February 5 1999 at Lake County, Indiana

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

The South 9 Feet of Lot 2, all of Lot 3 and the North 5 Feet of Lot 4, in Davidson's Tenth Addition to Whiting, as per plat thereof, recorded in Plat Book 5, Page 2, in the Office of the Recorder of Lake County, Indiana.
a/k/a: 1603 Central Ave., Whiting, IN 46394

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.

FILED
OCT 6 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Margaret M. Walsh
Margaret M. Walsh

Subscribed and sworn to before me, a Notary Public, this 25 day of SEP 2003.

"OFFICIAL SEAL"
Lori L. Shelby
Notary Public, State of Indiana
County of Porter
My Commission Expires Nov. 11, 2007

Lori L. Shelby
Notary Public

000451

This instrument prepared by: Margaret M. Walsh

CHICAGO TITLE INSURANCE COMPANY

* **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

Local No. 45 State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
THOMAS	JAMES	WALSH	MALE	7:41 A M	FEBRUARY 5, 1999

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)
339-30-3577	59			SEPT. 27, 1939	CHICAGO, ILLINOIS

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)
NO	N/A	HOSPITAL ☐ Inpatient XX ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
ST. CATHERINE HOSPITAL	EAST CHICAGO	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	MARGARET CROTTY	ACCOUNTING	MIDWEST CANVAS

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	WHITING	1603 CENTRAL AVENUE

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 +)
46394	☐ No XX Yes	XX No ☐ Yes	U.S.A.	XX No ☐ Yes	WHITE		1

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
THOMAS F. WALSH	JESSIE PUZ

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
MRS. MARGARET M. WALSH	1603 CENTRAL, WHITING, IN 46394	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 XX Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____	FEBRUARY 8, 1999 HERITAGE CREMATORY	PORTAGE, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
MARTIN A. DYBEL	FDE01019456	☐ No XX Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Martin A. Dybel	FDE01019456	BARAN & SON, INC., FDH83007267 1235-119TH ST., WHITING, IN 46394

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. Cardiopulmonary arrest	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

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)
	N/A	NO	N/A

CERTIFIER

29a. CERTIFIER (Check only one)

XX 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
S. Patel	01042343	FEB. 6, 1999

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

SATISH PATEL, M.D., 5500 HOHMAN AVENUE, HAMMOND, INDIANA 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Dr. Timothy Raykovich	2-9-99

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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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.