2

** TOTAL PAGE.10 **

LAKE COUNTY
FILED FOR RECORD

2004 038801

2004 MAY 12

MORRIS

AFFIDAVIT

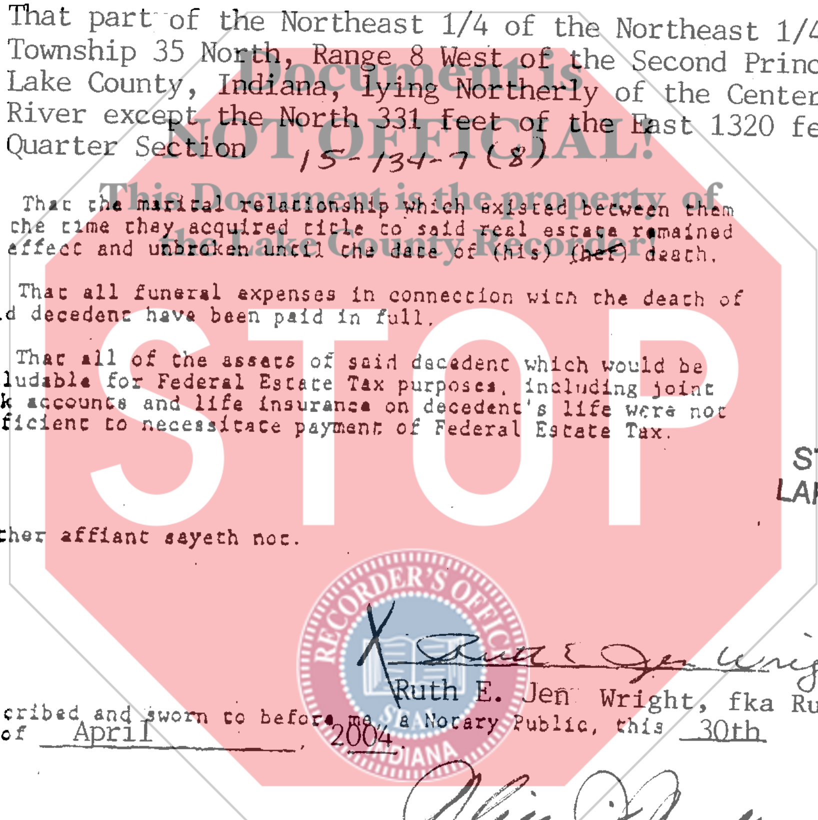
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Ruth E. Jen -Wright, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Robert T. Jen died (without leaving a will) ~~(leaving a will)~~ on July 2 19 99 at 4:55 PM

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

That part of the Northeast 1/4 of the Northeast 1/4 of Section 35, Township 35 North, Range 8 West of the Second Principal Meridian, in Lake County, Indiana, lying Northerly of the Center Line of Deep River except the North 331 feet of the East 1320 feet of said Quarter Quarter Section 15-134-7 (8)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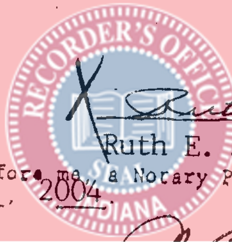
3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.

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.

FILED
MAY 11 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Further affiant sayeth not.



X [signature]
Ruth E. Jen Wright, fka Ruth E. Jen

Subscribed and sworn to before me, a Notary Public, this 30th day of April, 2004.

[signature]
Notary Public
Philip J. Ignarski

County of Residence: Lake My Commission expires 07/1706

0007

This instrument prepared by: Ruth E. Jen

Ticor CP 320040779

BANKERS TITLE

P.10 219 659 3675 TO 92555624 APR 06 2004 14:10 FR BANKERS TITLE

11 DC TH

20cc6

* **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. 1560-99 State No. ....

269566

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): ROBERT T. JEN
2. SEX: MALE
3a. TIME OF DEATH: 4:55 PM
3b. DATE OF DEATH (Month Day Yr): JULY 2, 1999
4. *SOCIAL SECURITY NUMBER: 315-52-6010
5a. AGE—Last Birthday (Years): 50
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day Yr): FEB. 6, 1949
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: —
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): RUTH PARLOS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): STEELWORKER
12b. KIND OF BUSINESS/INDUSTRY: US STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 9320 COLORADO STREET
13e. ZIP CODE: 46307
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): GEORGE JEN
19. MOTHER'S NAME (First, Middle, Maiden Surname): LORRAINE CEISLIK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): RUTH JEN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9320 COLORADO STREET, CROWN POINT, IN. 46307
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JULY 7, 1999 GRACELAND CEMETERY
21c. LOCATION—City or Town, State: VALPARAISO, INDIANA
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO: 01010711
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E. Burns
24b. LICENSE NUMBER (of Licensee): 01009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH#83002445 10101 S. BROADWAY, CROWN POINT, IN4630

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. Lung Cancer
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 90 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): —

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: M. Gasparis
29c. MEDICAL LICENSE NO: 01037515
29d. DATE SIGNED (Month, Day, Year): 7-6-99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MILTON GASPARIS, M. D., 1400 S. LAKE PARK AVENUE, HOBART, INDIANA 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): July 6, 1999

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.

THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPARTMENT
JUL 6 1999
Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
MAY 11 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

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