



# TICOR TITLE INSURANCE

2004 099501

## AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Sandra L. Holeman, being first duly sworn upon oath, deposes and says:

1. That Robin D. Holeman died on December 14, 2004 at 1:22 PM

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

See Attached

Document is NOT OFFICIAL!  
24-161-10+12 (30)

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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.

Further affiant sayeth not.

Sandra L. Holeman  
Sandra L. Holeman

Subscribed and sworn to before me, a Notary Public, this 19th day of November, 2004.

**FILED**

NOV 23 2004

STEPHEN R. STIGLICH  
Notary Public  
LAKE COUNTY AUDITOR

My Commission expires:

KIMBERLY KAY SCHULTZ  
Lake County  
My Commission Expires  
Oct 29, 2008

County of Residence:

This Instrument prepared by Sandra L. Holeman

924-8293  
TICOR TITLE INSURANCE  
Crown Point, Indiana

14-DC  
17

No: 920048293

**LEGAL DESCRIPTION**

Lots 10 and 12 in Wildwood Estates, in the Town of Cedar Lake, as per plat thereof, recorded in Plat Book 45 page 95, in the Office of the Recorder of Lake County, Indiana.



This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Robin D. Holeman				2 SEX Male	3a TIME OF DEATH 1:22 P M	3b DATE OF DEATH (Month, Day, Year) December 14, 2002
4 SOCIAL SECURITY NUMBER 310-68-4861	5a AGE—Last Birthday (Years) 45	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) 06-14-1957	7 BIRTHPLACE (City and State or Foreign Country) Hammond, IN	
8a WAS DECEASED A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? NA	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) Porter Memorial Hospital			9c CITY, TOWN, OR LOCATION OF DEATH Valparaiso	9d COUNTY OF DEATH Porter		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Sandra Moelhman	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Electrician		12b KIND OF BUSINESS/INDUSTRY Hammond School Sys.		
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Cedar Lake		13d STREET AND NUMBER 12941 Wildwood St.		
13a ZIP CODE 46303	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 DECEASED 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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 NA	
18 FATHER'S NAME (First, Middle, Last) Claude Holeman			19 MOTHER'S NAME (First, Middle, Maiden Surname) Joyce Anne Davies			
20a INFORMANT'S NAME (Type/Print) Sandra Holeman		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12941 Wildwood Cedar Lake, IN		20c Relationship Wife		
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)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 18, 2002 German Methodist Cemetery		21c LOCATION—City or Town, State Cedar Lake, IN		
22a EMBALMER'S NAME Craig Malone		22b EMBALMER'S LICENSE NO. 1022392	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FD01007697	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burdan Funeral Home FH83002461 12901 Wicker Ave. Cedar Lake, IN 46303			
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 <i>Cardiogenic Shock</i>			Approximate Interval Between Onset and Death 3 hrs	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b <i>Extensive anterior wall Myocardial infarct</i>			3 hrs	
		c <i>Complete Heart Block</i>			3 hrs	
		d				
PART II Other significant conditions		Conditions contributing to death but not previously stated in Part I <i>MI</i>		27 WAS DECEASED 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)
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>Keith Adress</i>			29c MEDICAL LICENSE NO. D1038771	29d DATE SIGNED (Month, Day, Year) 12/20/02		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/print) <i>Keith Adress</i> 2000 Roosevelt Rd. Valpo, IN 46383						
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32 DATE FILED (Month, Day, Year) December 20, 2002	
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	
		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.				

