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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2005 053450

2005 JUN 14

Chicago Title Insurance Company

Chicago Title Insurance Company

620053917

SURVIVORSHIP AFFIDAVIT

STATE OF

COUNTY OF

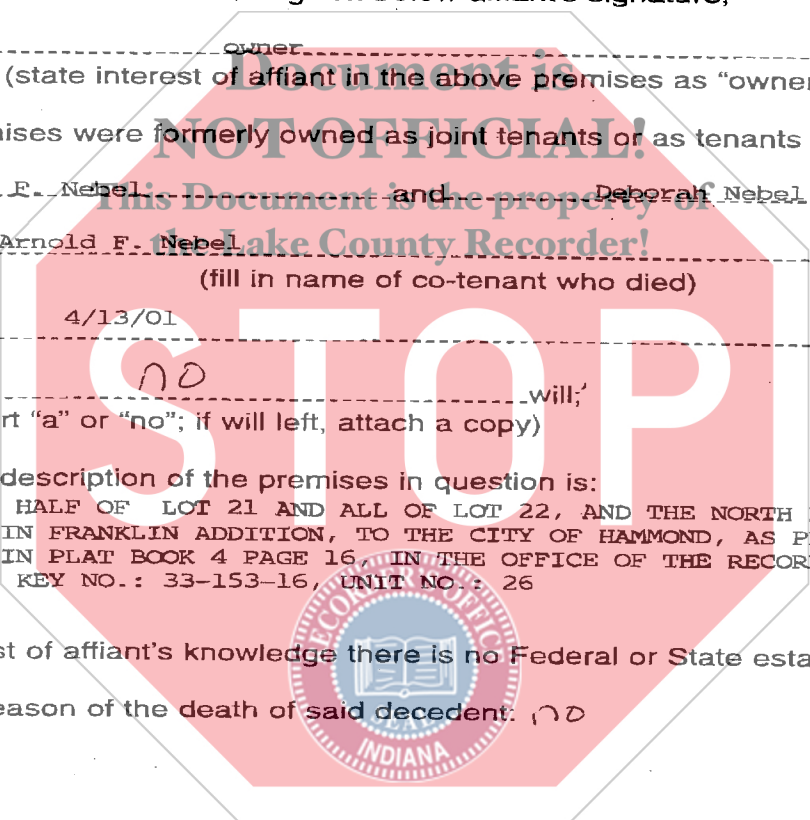
} S.S.

On this June 14, 2005 before me personally appeared
(insert date)

Deborah Nebel

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is owner
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by
Arnold F. Nebel and Deborah Nebel;
4. Said Arnold F. Nebel
(fill in name of co-tenant who died)
died on 4/13/01
leaving no will;
(insert "a" or "no"; if will left, attach a copy)
5. The legal description of the premises in question is:
THE SOUTH HALF OF LOT 21 AND ALL OF LOT 22, AND THE NORTH HALF OF LOT 23, IN
BLOCK 4, IN FRANKLIN ADDITION, TO THE CITY OF HAMMOND, AS PER PLAT THEREOF,
RECORDED IN PLAT BOOK 4 PAGE 16, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY,
INDIANA. KEY NO.: 33-153-16, UNIT NO.: 26
6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent: no



FILED

JUN 28 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

002233

1402
CT
RM

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

no

(If answer is "Yes," identify the divorce proceedings:

no

8. Affiant's relationship to the deceased was Wife

Signature: Deborah Nebel

Deborah Nebel
Address: 6238 Garfield St., Hammond, IN 46324

Subscribed and sworn to before me by the affiant

this June 14, 2005

(insert date)

Barbara J. Lappellere
Notary Public

My Commission Expires 4.27.08

This instrument prepared by Mercantile National Bank / M. Waechter

**This Document is the property of
the Lake County Recorder!**

STOP



**Document is
NOT OFFICIAL!**

* 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

THIS CERTIFIES THE FOLLOWING IS A COMPLETE COPY OF DEATH CERTIFICATE HANDED BY HEALTH DEPARTMENT

Local No. 273

CERTIFICATE OF DEATH

State Date Issued: May 27, 2005

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) ARNOLD F. NEBEL		2 SEX Male		3a TIME OF DEATH 12:29		3b DATE OF DEATH (Month Day Year) April 13, 2001	
4 *SOCIAL SECURITY NUMBER 309-58-5102		5a AGE—Last Birthday (Years) 48		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr) June 17, 1952		7 BIRTHPLACE (City and State or Foreign Country) Hammond, 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 <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			
9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy				9c CITY, TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Deborah Brajewski		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Maintenence		12b KIND OF BUSINESS/INDUSTRY Mt. Zion Retirement	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6238 Garfield Avenue	
13e ZIP CODE 46324		13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		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) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) College (11-14) 12th					
18 FATHER'S NAME (First Middle Last) Nathan Nebel				19 MOTHER'S NAME (First Middle Maiden Surname) Sarah Kruskol			
20a INFORMANT'S NAME (Type/print) Deborah Nebel				20b MAILING ADDRESS (Street and Number or Rural Route Number, City, Town, State, Zip Code) 6238 Garfield Ave., Hammond, IN 46324		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) April 17, 2001 Holy Cross Cemetery				21c LOCATION—City or Town, State Calumet City, Illinois	
22a EMBALMER'S NAME Dean G. Wagner				22b EMBALMER'S LICENSE NO. 8800057		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licensee) 8800057		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Solon Funeral Home FH83002893 7109 Calumet Ave., Hammond, IN 46324			
26 PART I Enter the disease, 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. <u>CARDIAC ARRHYTHMIA</u> b. <u>END STAGE RENAL DISEASE</u> c. <u>DIABETES MELLITUS I</u> d. _____ Conditions, if any, which gave rise to the immediate cause stating the underlying cause last <u>10AY</u> <u>ONE YEAR</u>							
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) N/A			
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>Mark Kevin, M.D.</i>				29c MEDICAL LICENSE NUMBER 01036785		29d DATE SIGNED (Month Day Year) April 16, 2005	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/print) Mark Kevin, M.D. 7905 Calumet Ave., Munster, IN. 46321 219-836-5800							
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Spemuda M.D.</i> 32 DATE FILED (Month Day Year) April 16, 2005							
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigator <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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.							

