

2006 017716

2006 MAR -3 AM 8:47

MICHAEL A. BROWN
Tax Key Number: 26-36-0148-0021

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SURVIVORSHIP AFFIDAVIT

I, Tracy Grigereit, being first duly sworn, state:

- 1. Affiant is a resident of Lake County, Indiana.
- 2. Affiant is the daughter of Walter E. Grigereit, who died a resident of Lake County, Indiana, on December 28, 1991.

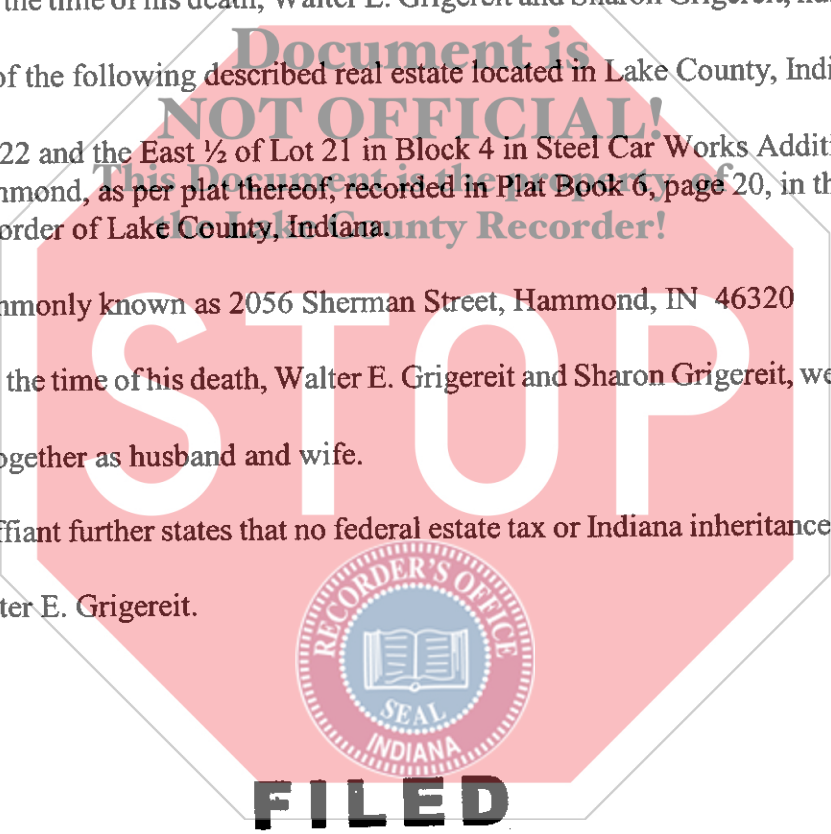
3. At the time of his death, Walter E. Grigereit and Sharon Grigereit, husband and wife, were the owners of the following described real estate located in Lake County, Indiana:

Lot 22 and the East 1/2 of Lot 21 in Block 4 in Steel Car Works Addition to Hammond, as per plat thereof, recorded in Plat Book 6, page 20, in the Office of the Recorder of Lake County, Indiana.

Commonly known as 2056 Sherman Street, Hammond, IN 46320

- 4. At the time of his death, Walter E. Grigereit and Sharon Grigereit, were not divorced and were living together as husband and wife.
- 5. Affiant further states that no federal estate tax or Indiana inheritance tax is due from the Estate of Walter E. Grigereit.

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FILED

MAR 03 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

\$15
 CK# 60783
 004697 CA

6. This Affidavit is made by the undersigned to confirm that ownership in the above-described real estate is now vested in Sharon Grigereit, and to induce the Auditor of Lake County, Indiana to reflect the correct ownership of such real estate on said Auditor's records.

Dated: March 1, 2006

Tracy Grigereit
Tracy Grigereit

Before me the undersigned, a Notary Public in and for said County and State, personally appeared Tracy Grigereit and being first duly sworn by me upon her oath, states that the facts alleged in the foregoing Affidavit are true.

Signed and sealed this 1st day of March, 2006.

My Commission Expires: November 29, 2012

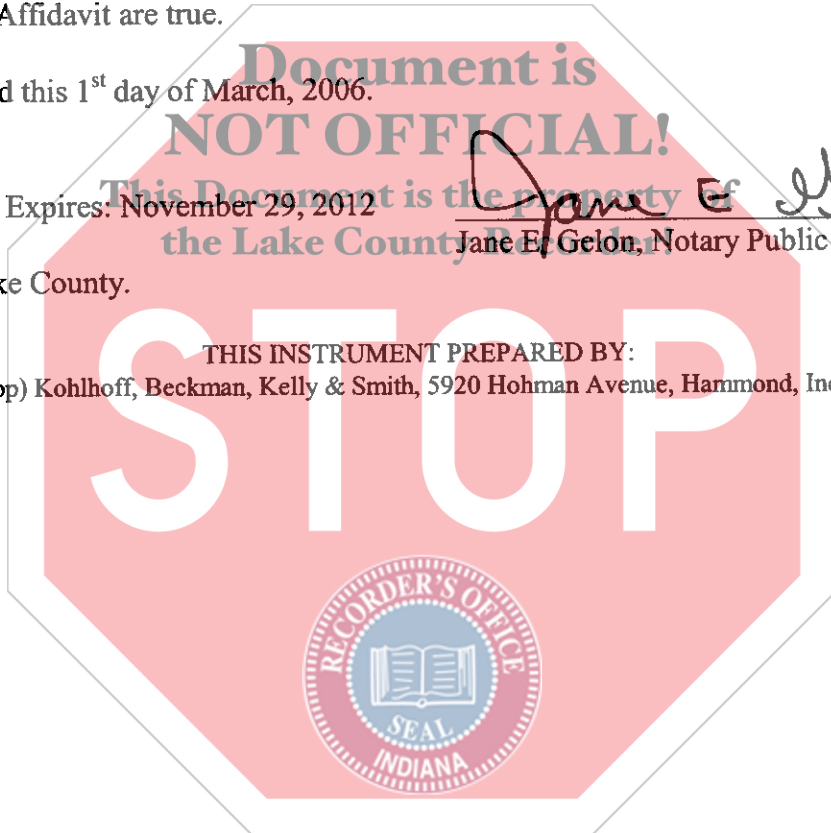
A resident of Lake County.

Document is
NOT OFFICIAL!

This Document is the property
of the Lake County Recorder's Office

Jane E. Gelon
Jane E. Gelon, Notary Public

THIS INSTRUMENT PREPARED BY:
Alissa (Resop) Kohlhoff, Beckman, Kelly & Smith, 5920 Hohman Avenue, Hammond, Indiana 46320



THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Dec 30, 1991 Date Issued
Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 1082

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First, Middle, Last) WALTER E. GRIGEREIT				2. SEX MALE	3a. TIME OF DEATH 12:00 AM	3b. DATE OF DEATH (Month, Day, Yr.) DECEMBER 28, 1991	
4. SOCIAL SECURITY NUMBER [REDACTED]	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.) Jan. 3, 1943	7. BIRTHPLACE (City and State or Foreign Country) Farmington, New Mexico		
8a. WAS DECEDENT A U.S. VETERAN? no	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? no	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 Hospital			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Sharon Obstedt		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Carman		12b. KIND OF BUSINESS/INDUSTRY I.H.B. Railroad	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hammond		13d. STREET AND NUMBER 2056 Sherman Street	
13e. ZIP CODE 46320	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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 (0-12) 11 College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) Carl N. Grigereit			19. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Morgan		
20a. INFORMANT'S NAME (Type/Print) Mrs. Sharon Grigereit			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2056 Sherman St. Hammond, IN 46323		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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 31, 1991 Park Crematory		21c. LOCATION—City or Town, State Park Forest, IL			
22a. EMBALMER'S NAME David McCoy		22b. EMBALMER'S LICENSE NO. FD08700581		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John C. [Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD01013507		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323			
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. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF) b. Sclerosis 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						Approximate Interval Between Onset and Death	
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) 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 checked="" 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>[Signature]</i>				29c. MEDICAL LICENSE NO. 61135923	29d. DATE SIGNED (Month, Day, Year) Dec. 30, 1991		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) J.A. Cahan, M.D. 7905 Calumet Avenue Munster, IN 46321							
31. HEALTH OFFICER'S SIGNATURE <i>Franklin D. [Signature]</i>					32. DATE FILED (Month, Day, Year) December 30, 1991		
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.					

Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury.

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security Numbers in the attached document.

2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, the undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.



Alissa Kohlhoff
Alissa (Resop) Kohlhoff