TICOR TITLE INSURANCE

2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 AUG -7 AM 9:02

MICHAEL A. BROWN
RECORDER

AFFIDAVIT

2006 068063

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

CAROLYN JOAN COATES, being first duly sworn upon oath, deposes and says:

1. That BOBBY D. COATES died on 8-26, 1998 at MUNSTER.

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

LOT 17 IN GRAND HESSVILLE HEIGHTS ADDITION TO THE CITY OF HAMMOND AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 31 PAGE 87, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY INDIANA,

7344 NEBRASKA DR, HAMMOND IN 46323 26-33-233-17

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 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.

Carolyn Joan Coates

Subscribed and sworn to before me, a Notary Public, this 13th day of JULY, 19 2006

Notary Public

My Commission expires:
12-7-2008

"I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law." Sandra Poyovich

County of Residence:
LAKE

This Instrument prepared by CAROLYN JOAN COATES

14-
ZP
IF

FILED

AUG - 4 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

TOTAL P.02

TICOR - SCHERERVILLE - 92006706

014396

* **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. 17-23-98 State No. ....

264426

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): BOBBY D. COATES
2. SEX: MALE
3a. TIME OF DEATH: 7:52 PM
3b. DATE OF DEATH (Month, Day, Yr.): AUGUST 26, 1998
4. *SOCIAL SECURITY NUMBER: 304-24-0354
5a. AGE—Last Birthday (Years): 73
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): JUNE 5, 1925
7. BIRTHPLACE (City and State or Foreign Country): Pike Co., Indiana
8a. WAS DECEDENT A U.S. VETERAN?: Yes WWII
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1946
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): The Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Carolyn Joan Sprinkle
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pipefitter
12b. KIND OF BUSINESS/INDUSTRY: L.T.V. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7344 Nebraska Avenue
13e. ZIP CODE: 46323
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 +): 1

PARENTS

18. FATHER'S NAME (First, Middle, Last): Fred Coates
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Colvin

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mrs. Carolyn Joan Coates
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7344 Nebraska Avenue Hammond, IN 46323
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ________
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 29, 1998 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, IN
22a. EMBALMER'S NAME: John C. Ault
22b. EMBALMER'S LICENSE NO.: FD01013507
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John C. Ault
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

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 ... each line.

I CERTIFY THIS TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. ACUTE ABDOMINAL DISASTER
DUE TO (OR AS A CONSEQUENCE OF):
b. HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death

AUG 28 1998

Alexander S. Williams MD
LAKE COUNTY HEALTH COMMISSIONER

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

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.T. Nootens M.D.
29c. MEDICAL LICENSE NO.: 01042703
29d. DATE SIGNED (Month, Day, Year): 8-28-98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M.T. Nootens, M.D. 7905 Calumet Avenue Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): August 28, 1998

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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1