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AFFIDAVIT

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA)
COUNTY OF LAKE) 2006) 381744

2006 SEP 18 AM 10:47

DONNA K. FRIZZELL, being first duly sworn upon oath, deposes and says:

1. That the Affiant is the daughter and has personal knowledge of the marital status of the Decedent.
2. That **LORETTA A. TRATEBAS** died on March 12, 2004 at Regency Place, Lake County, Indiana.
3. That the Decedent and **HAROLD L. TRATEBAS** were duly and legally married at the time they acquired title as Husband and Wife in the following described real estate:
LOTS 27 AND 28, IN BLOCK 5 IN THE BALDWIN ADDITION TO GARY, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 10 PAGE 35, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
4. 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 her death.
5. That all funeral expenses in connection with the death of said decedent have been paid in full.
6. That all of the assets of said decedent which would be included 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.

COMMUNITY TITLE COMPANY
FILE NO 135433

Donna K. Frizzell
Donna K. Frizzell

Subscribed and sworn to before me, a Notary Public this 18th day of September, 2006.

My Commission Expires:
County of Residence:



Karen Craig, Notary Public

This instrument prepared by **PATRICK J. McMANAMA**, Attorney-at-Law, Attorney ID No. 9534-45.
No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

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.

Karen Craig
Signature of Preparer

Karen Craig
Name of Preparer

FILED

SEP 18 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

018572

C.M.
14:00
AM

* 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

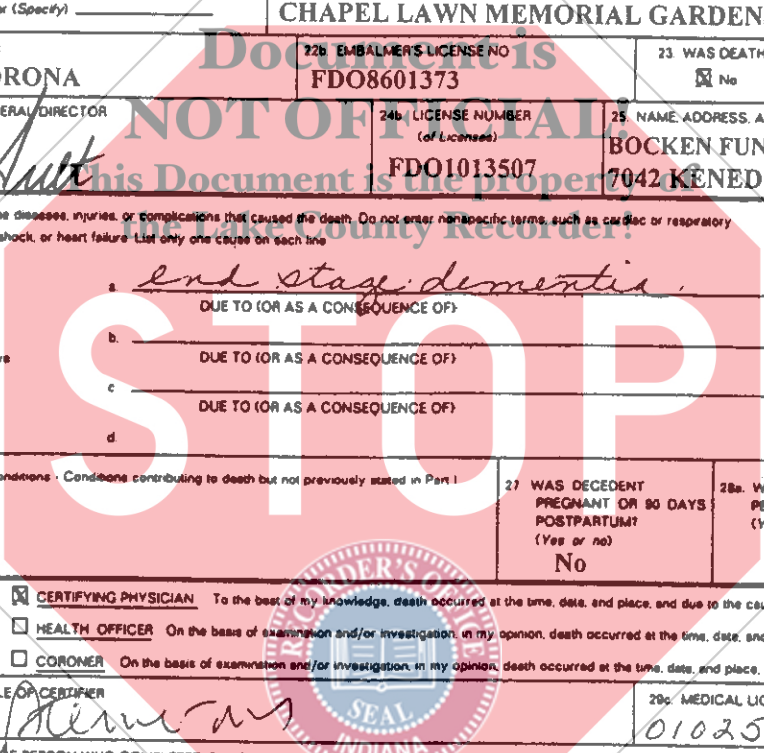
Local No. 689-04

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) LORETTA A. TRATEBAS				2 SEX Female		3a. TIME OF DEATH 10:10 AM		3b. DATE OF DEATH (Month, Day, Yr.) March 12, 2004	
4. *SOCIAL SECURITY NUMBER 311-18-3510		5a. AGE—Last Birthday (Years) 83	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) July 5, 1920		7. BIRTHPLACE (City and State or Foreign Country) Paynesville, Kentucky		
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 type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence					
9b. FACILITY NAME (If not institution, give street and number) REGENCY PLACE				9c. CITY, TOWN, OR LOCATION OF DEATH DYER		9d. COUNTY OF DEATH LAKE			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) HAROLD TRATEBAS		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b. KIND OF BUSINESS/INDUSTRY OWN HOME			
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND		13d. STREET AND NUMBER 6645 PARRISH AVENUE				
13e. ZIP CODE 46323	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g. ON A FARM? <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) 12 College (1-4 or 5 +)	
18. FATHER'S NAME (First, Middle, Last) CLAUDE KERRICK				19. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL KENNEDY					
20a. INFORMANT'S NAME (Type/Print) DONNA FRIZZELL				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7532 GRAND AVENUE, HAMMOND, IN 46323				20c. Relationship DAUGHTER	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <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) Mar 15, 2004 CHAPEL LAWN MEMORIAL GARDENS			21c. LOCATION—City or Town, State SCHERERVILLE IN			
22a. EMBALMER'S NAME JOSE G. CORONA			22b. EMBALMER'S LICENSE NO. FDO8601373		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) FDO1013507		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BOCKEN FUNERAL HOME, INC. FH83002801 7042 KENEDY AVENUE, HAMMOND, IN				
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. end stage dementia a. end stage dementia 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) 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>[Signature]</i>						29c. MEDICAL LICENSE NO. 01025591		29d. DATE SIGNED (Month, Day, Year) 3-15-04	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ALEXANDER STEMER, M.D. 919 MAIN STREET, SUITE 202, DYER, IN 46311-									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) March 16, 2004			
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <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			
			34a. 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) THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. MAR 16 2004						



DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER