2006 082002

2006 SEP 15 P 3:55

MICHAEL A. BROWN

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AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Lynn Ogrentz, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Gilbert Ogrentz died (without leaving a will) (leaving a will) on 12/13/04 20___ at _____

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

LOT 3 AND OUTLOT A IN VALLEY WOOD, AN ADDITION TO LAKE COUNTY, INDIANA AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 50, PAGE 95, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA. SUBJECT TO ALL EASEMENTS, RESTRICTIONS AND COVENANTS OF RECORD.

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.

FILED

SEP 15 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Further affiant sayeth not.

I AFFIRM, UNDER THE PENALTIES OF PERJURY, THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW.

Lynn Ogrentz

Subscribed and sworn to before me, a Notary Public, this 30th day of July, 2006.

Gina L. Iguardia
Notary Public Seal State of Indiana
Lake County
My Commission Expires 01/15/2012

Notary Public

This instrument prepared by: Lynn Ogrentz

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2642146864
LD

018471

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal."

Local No. 302604

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.....

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)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
GILBERT	C	OGRENTZ	Male	8:50 AM	December 13, 2004

4. *SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
349-36-2654	60			November11,1944	LEESVILLE Louisiana

PLACE OF DEATH (Check only one See instructions)

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
Yes	1970		

9a. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Anthony Medical Center	Crown Point	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY
Married	LYNN MARIE KROSS	OWNER-OPERATOR	TUFF CAR COM.

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	CROWN POINT	4933 W 125TH AVE.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE — American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46307	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	8	N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
FRANCES CHESTER OGRENTZ	PANSY LOUISE KNAPP

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
LYNN MARIE OGRENTZ	4933 W 125TH AVE., CROWN POINT, IN 46307	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	December 17, 2004 HOLY CROSS CEMETERY	Calumet City, Illinois

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
TERRENCE P. BURNS	1013890	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James T. Burns	FD01009461	BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana

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 arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. anoxic encephalopathy & Seizures	
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Sudden Cardiac Death	
	c. DUE TO (OR AS A CONSEQUENCE OF): Respiratory failure.	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
X	01055547A	12/13/04

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	32. DATE FILED (Month, Day, Year)
DR. KAIS YEHYAWI 8895 BROADWAY, MERRILLVILLE, IN 46410	December 14, 2

31. HEALTH OFFICER'S SIGNATURE

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.
December 13, 2004	