2

2007 020672

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Richard Hauer aka Richard T. Hauer, being first duly sworn upon oath, deposes and says:

1. That Dorothy Hauer aka Dorothy R. Hauer died on 10-26-2005 at Community Hospital.

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

Lot 16, Sandalwood Subdivision Phase One, an Addition to the Town of Highland, Indiana, as per plat thereof, recorded in Plat Book 82 page 91, in the OFfice of the Recorder of Lake County, Indiana, except the West 40.5 feet by parallel lines from the West line thereof. 27-631-67

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.

X Hauer
Richard Hauer aka Richard T. Hauer

Subscribed and sworn to before me, a Notary Public, this 22nd day of February, ~~19~~ 2007

MARY J. MOORE
Notary Public Seal State of Indiana
Lake County
My Commission Expires 7-13-2014

Notary Public

My Commission expires:

County of Residence:
LAKE

This instrument prepared by Richard Hauer

FILED

MAR - 7 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

"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." Chris Burk

0702024RT Region Ticor Highland

003183

$14
TI
CA

* 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.

Local No. 3703-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. _____

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

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.)
Dorothy Rita Hauer	Female	9:45 AM	October 26, 2005

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)
350-22-4631	76			February 19, 1929	Chicago, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
No	N/A	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Community Hospital	Munster, IN	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	Richard T. Hauer	Secretary	Office Work

13a. RESIDENCE-STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Highland	3632 Franklin Avenue

13a. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. AS 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+)
46322	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Joseph Chengary	Stella Rita Koronkowski

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
Richard T. Hauer	3632 Franklin Avenue, Highland, IN 46322	Husband

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)	October 31, 2005 Kelly-Carroll Cremation Services	Gary, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Timothy Bowler	FD20500035	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Leonard Bergsma	FD08800305	Kuiper Funeral Home 9039 Kleinman Road Highland, IN 46322 FH10300021

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

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

		Approximate Interval Between Onset and Death
a.	Cardiopulmonary arrest	1 hr
b.	DUE TO (OR AS A CONSEQUENCE OF): Resp tory failure due to	1 day
c.	DUE TO (OR AS A CONSEQUENCE OF): Lung Cancer with Metastens.	3 yrs
d.	DUE TO (OR AS A CONSEQUENCE OF): Non Small cell Cancer	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

osteoporosis.

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)
[signature]	01033072	10-28-05

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Jayshree S. Bhatt M.D. 9124 Columbia Ave Munster IN 4632

31. HEALTH OFFICER'S SIGNATURE

Susan M. Gast D.O.

32. DATE FILED (Month, Day, Year)

Oct 28 2005

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				

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)

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 (R5/1-99)