2

TICOR TITLE INSURANCE

2008 063102

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Mary Jean Brady, being first duly

Sworn upon oath, deposes and says:

1. That Robert J. Brady died on July 19, 1997 at 12nd Unit Med Contai

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

Lot 15 in Phillips Cline Addition, in the Town of Griffith, as per plat thereof, recorded in Plat Book 25 page 18, in the Office of the Recorder of Lake County, Indiana.

45-07-35-102-023.000-006

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.

Further affiant sayeth not.

Mary Jean Brady
Mary Jean Brady

Subscribed and sworn to before me, a Notary Public, this 29th day of August, 2008.

14 TI

DENISE K. ZAWADA
Lake County
My Commission Expires
July 10, 2014

Notary Public: Denise K. Zawada

My commission expires: 7/10/14

County of Residence: Lake

"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

FILED

This Instrument prepared by: Mary Jean Brady

SEP 05 2008

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

928-4848
TICOR S?

015599

ISSUED BY MARION COUNTY HEALTH DEPARTMENT

ON ESTATE: Disclosure of the ed to pursue our responsibilities y and there will be no penalty for

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. 005245

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

1. DECEASED—NAME (First, Middle, Last): Robert Brady			2. SEX: Male	3a. TIME OF DEATH: 1048A M	3b. DATE OF DEATH (Month, Day, Yr): July 19, 1997	
4. *SOCIAL SECURITY NUMBER: [redacted]-5956	5a. AGE—Last Birthday (Years): 61	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr): August 30, 1935	7. BIRTHPLACE (City and State or Foreign Country): Evanston, Illinois	
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1965	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): University Hospital		9c. CITY, TOWN, OR LOCATION OF DEATH: Indianapolis		9d. COUNTY OF DEATH: Marion		
10. MARITAL STATUS (Specify): married	11. SURVIVING SPOUSE (If wife, give maiden name): Mary Jean Markwalder	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Claims Supervisor		12b. KIND OF BUSINESS/INDUSTRY: Insurance Co.		
13a. RESIDENCE—STATE: Indiana	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Griffith		13d. STREET AND NUMBER: 708 N. Harvey St.		
13e. ZIP CODE: 46319	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): Col lege (1-4 or 5 +): 4
18. FATHER'S NAME (First, Middle, Last): John Brady				19. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Clavey		
20a. INFORMANT'S NAME (Type/Print): Mary Jean Brady		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 708 N. Harvey St. Griffith, IN 46319			20c. Relationship: Wife	
21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 23, 1997 Mount Mercy Cemetery			21c. LOCATION—City or Town, State: Calumet Twp. Indiana	
22a. EMBALMER'S NAME: Jeffery A. Bell		22b. EMBALMER'S LICENSE NO.: FD08800290		23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR: Ronald A. Reed		24b. LICENSE NUMBER (of Licensee): FD01001081		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home FH8300-7500 9039 Kleinman Rd. Highland, IN 46322		

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. Transplant rejection	
	DUE TO (OR AS A CONSEQUENCE OF):	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Idiopathic pulmonary Fibrosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

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

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	

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)
Michelle Louis MD	01045355	7/19/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Michelle Louis 550 univ blvd Indpls, IN 46202

31. HEALTH OFFICER'S SIGNATURE: Virginia A. Caine, M.D.

32. DATE FILED (Month, Day, Year): JUL 24 1997

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

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.

NOT VALID UNLESS MACHINE NUMBERED AND SIGNED WITH BLUE INK ON THE REVERSE SIDE