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TICOR TITLE INSURANCE

2009 023247

AFFIDAVIT

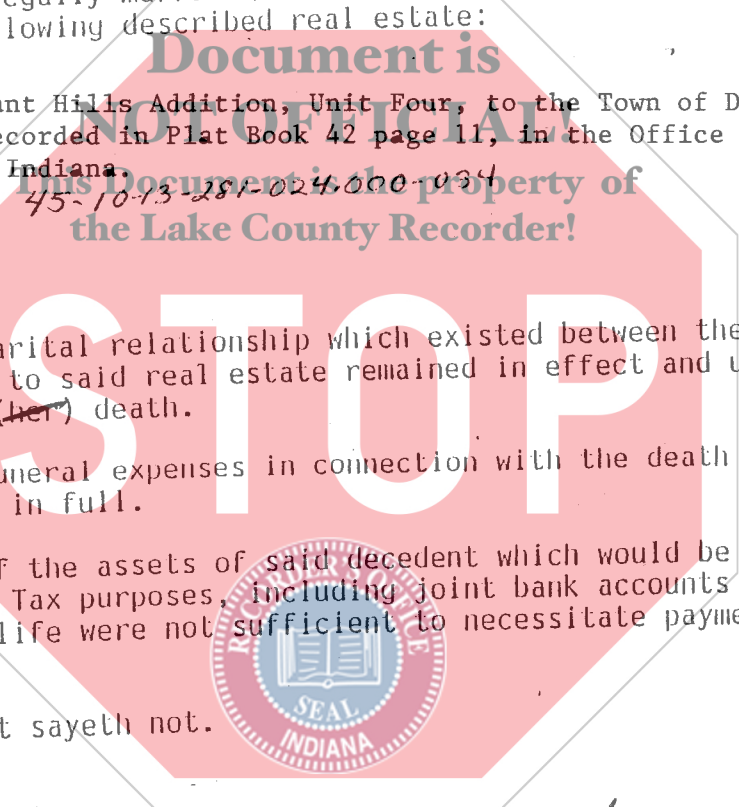
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Sandra K. Ketelaar, being first duly sworn upon oath, deposes and says:

1. That Thomas D. Ketelaar at Dyer, Indiana 11/11 September 24, 2007

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

Lot 17 in Pheasant Hills Addition, Unit Four, to the Town of Dyer, as per plat thereof, recorded in Plat Book 42 page 11, in the Office of the Recorder of Lake County, Indiana.



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.

Sandra K. Ketelaar

Sandra K. Ketelaar

Subscribed and sworn to before me, a Notary Public, this 6th day of April, 11/9 2009.



Shannon Stiener

Notary Public

(Shannon Stiener)

My Commission expires:

FILED

3-14-15

APR - 8 2009

County of Residence:

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Lake

This Instrument prepared by Sandra K. Ketelaar

"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

002547 *fb*

928-3548
TICOR SO

NOTION ESTATE: The Social Security # is requested by this state agency in order to fulfill its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 2305-07

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) Thomas Dale Ketelaar				2. SEX Male		3a. TIME OF DEATH 2:33 A M		3b. DATE OF DEATH (Month, Day, Year) September 24, 2007					
4. *SOCIAL SECURITY NUMBER ██████████ 0936		5a. AGE - Last Birthday (Years) 60		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) January 14, 1947		7. BIRTHPLACE (City and State or Foreign Country) Evergreen Park, Illinois			
8a. WAS DECEASED A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1969		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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence									
9b. FACILITY NAME (If not institution, give street and number) 741 Osage Drive						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) Sandra Hanish		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Purchasing Manager			12b. KIND OF BUSINESS/INDUSTRY Avery Dennison						
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Dyer			13d. STREET AND NUMBER 741 Osage Drive						
13e. ZIP CODE 46311		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEASED 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. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			
18. FATHER'S NAME (First, Middle, Last) Peter Jacob Ketelaar						19. MOTHER'S NAME (First, Middle, Maiden Surname) Marjorie Spoolstra							
20a. INFORMANT'S NAME (Type/Print) Sandra Ketelaar				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 741 Osage Drive Dyer, Indiana 46311				20c. Relationship Wife					
21a. METHOD OF DISPOSITION <input checked="" 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) September 27, 2007 Chapel Lawn Memorial Gardens				21c. LOCATION - City or Town, State Schererville, Indiana					
22a. EMBALMER'S NAME: Steven J. Struck				22b. EMBALMER'S LICENSE NO. FDO 8600181		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Steven J. Struck</i>				24b. LICENSE NUMBER (of Licensee) FDO 8600181		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Chapel Lawn Funeral Home FH19900051 8178 Cline Ave Schererville, IN 46375							
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. <u>Cardiopulmonary Arrest</u>										Seconds			
b. <u>Metastatic Osteo Sarcoma</u>										Months			
c. _____										_____			
d. _____										_____			
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.													
27. WAS DECEASED 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>John A. Hoehn, D.O.</i>						29c. MEDICAL LICENSE NO. 02000872			29d. DATE SIGNED (Month, Day, Year) 09/25/07				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John A. Hoehn, D.O. 505 W. Lincoln Hwy. Schererville, IN 46375													
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>						THIS CERTIFIER THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON 31. DATE FILED (Month, Day, Year) September 26, 2007 LAKE COUNTY HEALTH DEPARTMENT.							
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could Not Be Determined <input type="checkbox"/> Suicide <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 SEP 26 2007				
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.									