

2

2009 060882



TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Martha N. Sigg, being first duly
sworn upon oath, deposes and says:

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2009 SEP -3 9AM 9:21
MICHAEL ABERGOM
RECORDER

- 1. That Reginald E. Allen, 49, at Hammond, IN, 4-12-07, died on 4-12-07.
- 2. That Martha N. Sigg and Reginald E. Allen were husband and wife at the time they acquired title as Joint Tenants WIFE to the following described real estate:

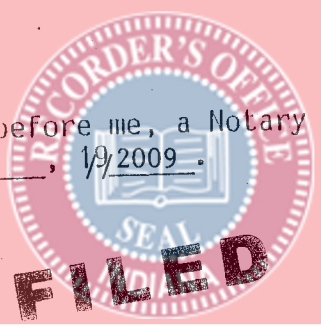
Lot 4 in Edgewood Unit One, an Addition to the Town of St. John, as per plat thereof, recorded in Plat Book 74 page 75, in the Office of the Recorder of Lake County, Indiana.

45-11-30-364-007-000-635

- 3. That ~~the marital relationship~~ ~~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.

Subscribed and sworn to before me, a Notary Public, this 28th day of 14 August 28, 19 2009.
Martha N. Sigg
Martha N. Sigg

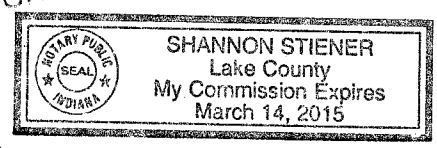


FILED

SEP 01 2009

Shannon Stiener
Notary Public

My Commission expires: 3-14-15
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR



County of Residence:
Lake

016179

This Instrument prepared by Martha N. Sigg

"I affirm, under the penalties for perjury, that I have taken reasonable care to ascertain the identity number in this document, unless required by law." Chris Burk

TICOR 80

NOTATION: The Social Security # is requested by this state agency in order to establish statutory responsibility. Disclosure is required by law and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 230

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Reginald E. Allen		2. SEX Male	3a. TIME OF DEATH 4:50A.M.	3b. DATE OF DEATH (Month, Day, Year) April 12, 2007	
4. SOCIAL SECURITY NUMBER [REDACTED]-2981	5a. AGE—Last Birthday (Years) 76	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours MINUTES	6. DATE OF BIRTH (Mo., Day, Yr.) MARCH 3/13/1931	
7. BIRTHPLACE (City and State or Foreign Country) Philadelphia, PA	8a. WAS DECEDENT A U.S. VETERAN? No				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) Select Specialty		9c. CITY, TOWN, OR LOCATION OF DEATH Hammond	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Divorced	11. SURVIVING SPOUSE (If wife, give maiden name) None	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Prof. Emeritus	12b. KIND OF BUSINESS/INDUSTRY Northwestern Univ.		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION St. John	13d. STREET AND NUMBER 9022 Maplewood St.		
13e. ZIP CODE 46373	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	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+) 9		18. FATHER'S NAME (First, Middle, Last) Amos Samuel Allen			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Bodine			20a. INFORMANT'S NAME (Type/Print) Martha H. Sigg		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9022 Maplewood St., St. John, IN 46373		20c. Relationship Life Partner			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) April 14, 2007 Regional Crem. Munster, IN.		21c. LOCATION—City or Town, State	
22a. EMBALMER'S NAME James Retkowski		22b. EMBALMER'S LICENSE NO. FD09200077	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Retkowski</i>		24b. LICENSE NUMBER (of Licensee) FD09200077	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Elmwood Chapel FHD#19900052 111300 W. 97th LN. St. John, IN 46373		
26. PART I Enter the disease, 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) DUE TO (OR AS A CONSEQUENCE OF) <i>Pneumonia</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, naming the underlying cause last 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) 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. 01061248	29d. DATE SIGNED (Month, Day, Year) 4/13/2007		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) DR. Thachonkary, 2809 Calumet Avenue Munster, IN 46321					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) April 13, 2007		
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
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.			