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:

1. That Reginald E. Allen died on 4-12-07, ~~19~~ at Hammond, In.

2. That Martha N. Sigg and Reginald E. Allen ~~were duly and legally married~~ at the time they acquired title as ~~husband and wife~~ Joint Tenants 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.
45-11-30-304-002.000-035

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.

Martha N. Sigg
Martha N. Sigg

Subscribed and sworn to before me, a Notary Public, this 28th day of August 28, ~~19~~2009 .

14
$ ~~12~~
TI
CA

Notary Public
Shannon Stiener

My Commission expires:
3-14-15

SHANNON STIENER
Lake County
My Commission Expires
March 14, 2015

016179

County of Residence:
Lake

This Instrument prepared by Martha N. Sigg

"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

TICOR SO

ˈNTION ESTATE: The Social Security # is ˈuested by this state agency in order to .s statutory responsibility. Disclosure is y and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 230

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): Reginald E. Allen
2. SEX: Male
3a. TIME OF DEATH: 4:50A.M
3b. DATE OF DEATH (Month, Day, Yr): 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? ------N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ 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: ☐ No X Yes
13g. ON A FARM? XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): XX No ☐ 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

PARENTS

18. FATHER'S NAME (First, Middle, Last): Amos Samuel Allen
19. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Bodine

INFORMANT

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 Partne

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial XX Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 14, 2007 Regional Crem.
21c. LOCATION—City or Town, State: Munster, IN.
22a. EMBALMER'S NAME: James Betkowski
22b. EMBALMER'S LICENSE NO.: FD09200077
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F. Betkowski
24b. LICENSE NUMBER (of Licensee): FD09200077
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Elmwood Chapel FHD#19900052 11300 W. 97th LN. St.John, IN 46373

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. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

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

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: M.D.
29c. MEDICAL LICENSE NO: 01061248
29d. DATE SIGNED (Month, Day, Year): 4/13/2007 (April)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. Thachenkary 8808 Calumet Avenue Munster In 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: MD
32. DATE FILED (Month, Day, Year): April 13, 2007

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

SDH06-004 State Form 10110 (R5/1-99)