

TICOR TITLE INSURANCE

2009 079787

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Robert R. Satterlee, being first and last name of the affiant, sworn upon oath, deposes and says:

- 1. That Jean Satterlee, 1993 at Hammond, Indiana.
2. That Robert R. Satterlee and Jean Satterlee were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 1, in Block 10, in Frank Hammond's Addition to Hammond, as per plat thereof, recorded in Plat Book 17, page 19, in the Office of the Recorder of Lake County, Indiana.
45-07-64-381-012.000-023

- 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 (1/15) (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.

This Document is the property of the Lake County Recorder

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

My Commission expires: 7-19-14

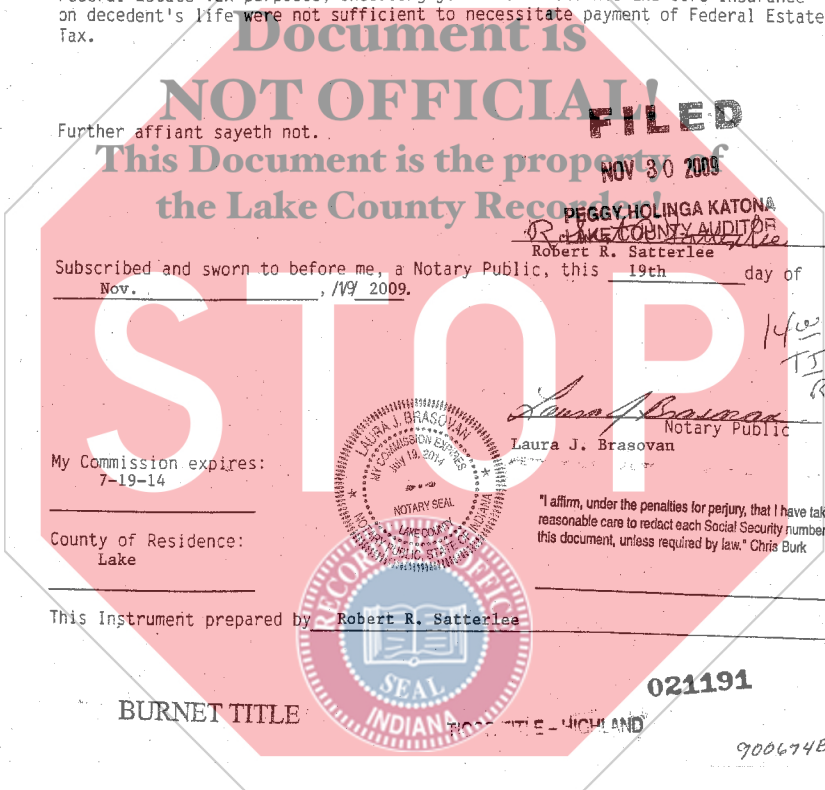
County of Residence: Lake

This Instrument prepared by Robert R. Satterlee

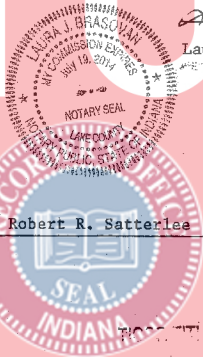
BURNET TITLE

021191

900674BT



STATE OF INDIANA LAKE COUNTY FILED FOR RECORDER 2009 DEC -2 AM 9:32 MICHAEL A. BRANN RECORDER



Laura J. Brasovan Notary Public

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

INDIANA STATE DEPARTMENT OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Franklin S. Orem, M.D.

Local No. 19

CERTIFICATE OF DEATH

Jan 1, 1993 Date Issued Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

RELATIVES

FORMANT

PROFESSOR

USE OF

RTIFIER

ALTH

RONER

ONLY

1. DECEASED—NAME (First, Middle, Last) JEAN L. SATTERLEE		2. SEX FEMALE	3a. TIME OF DEATH 3:45 AM	3b. DATE OF DEATH (Month, Day, Year) JANUARY 7, 1993	
4. SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE—Last Birthday (Years) 64	5b. UNDER 1 YEAR Months Days Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) June 10, 1928	7. BIRTHPLACE (City and State or Foreign Country) Everly, Iowa	
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 type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> EOC OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) Residence: 2650 Cleveland Street		9c. CITY, TOWN, OR LOCATION OF DEATH Hammond	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Robert R. Satterlee	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cafeteria Worker Morton Elmer Sch.	12b. KIND OF BUSINESS/INDUSTRY School City of Hammond		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond	13d. STREET AND NUMBER 2650 Cleveland Street	
13e. ZIP CODE 46323	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? <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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Walter W. Moeller			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Galdys M. Ewoldt		20. INFORMANT'S NAME (Type/Print) Mr. Robert R. Satterlee			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) January 9, 1993 Wharton Funeral Home		21c. LOCATION—City or Town, State Pleasant Hill Cemetery Aurelia, Iowa	
22a. EMBALLER'S NAME David F. McCoy		22b. EMBALLER'S LICENSE NO. FD08700581	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD01013507	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323		
25. PART I. Enter the disease, injury, or complication 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. Malignant fibrous histiocytoma					
26. PART II. Enter the disease, injury, or complication 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. Due to (or as a consequence of)					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no					
28. WAS AN AUTOPSY PERFORMED? (Yes or no) no					
29. 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. 27970	29d. DATE SIGNED (Month, Day, Year) Jan. 7, 1993		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (87B-423) (Type/print) S.D. Gailani, M.D. 9116 Columbia Avenue Munster, Indiana 46321					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> DATE FILED (Month, Day, Year) January 8, 1993					
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			

