2

TICOR TITLE INSURANCE

2009 079787

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2009 DEC -2 AM 8:32
MICHAEL A. BROWN
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Robert R. Satterlee, being first duly sworn upon oath, deposes and says:

1. That Jean Satterlee died on January 7, 1993 at Hammond, In

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.

45-07-04-381-012.000-023

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 (his) (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.

FILED
NOV 30 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Robert R. Satterlee

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

1402
TJ
RM

Laura J. Brasovan
Notary Public
Laura J. Brasovan

LAURA J. BRASOVAN
NOTARY PUBLIC SEAL
LAKE COUNTY, STATE OF INDIANA
MY COMMISSION EXPIRES JULY 19, 2014

My Commission expires:
7-19-14

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

This Instrument prepared by Robert R. Satterlee

BURNET TITLE

021191

900674BT

THIS CERTIFIES THE FOLLOWING IS A TRUE A
COMPLETE COPY OF DEATH ON FILE WITH T
HAMMOND HEALTH DEPARTMENT.
Franklin D. Premuda M.D.
Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 19

S Jan 9, 1993 Date Issued

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

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, Yr.): JANUARY 7, 1993
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE—Last Birthday (Years): 64
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Mo. Day, Yr.): 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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
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 Elem 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 ☐ 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): 12; College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last): Walter W. Moeller
19. MOTHER'S NAME (First, Middle, Maiden Surname): Galdys M. Ewoldt

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mr. Robert R. Satterlee
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2650 Cleveland St. Hammond, IN 46323
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
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. EMBALMER'S NAME: David F. McCoy
22b. EMBALMER'S LICENSE NO.: FD08700581
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR
24b. LICENSE NUMBER (of Licensee): FD01013507
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323

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. Malignant Gibsons histiocytoma DUE TO (OR AS A CONSEQUENCE OF)
b. DUE TO (OR AS A CONSEQUENCE OF)
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
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
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

28a. 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.
28b. SIGNATURE AND TITLE OF CERTIFIER: S.D. Gailani
28c. MEDICAL LICENSE NO.: 27970
28d. DATE SIGNED (Month, Day, Year): Jan. 7, 1993
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 28 (Type/Print): S.D. Gailani, M.D. 9116 Columbia Avenue Munster, Indiana 46321
31. HEALTH OFFICER'S SIGNATURE: Franklin D. Premuda M.D.
32. DATE FILED (Month, Day, Year): January 8, 1993

CORONER USE ONLY

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.