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# AFFIDAVIT

Come now Christine Keller as co-personal representatives of the Estate of Ernest F. Witham, which estate is presently pending in Lake Superior Court under the Case NO. 45D04-0807-EU-000048, and under penalty for perjury states:

1. Gloria C. Witham died in Lake County, Indiana, on November 7, 2006

2. At the time of her death decedent and Ernest F. Witham held title as tenants by the entireties of the following real estate:

Lot 1 and the East 20 feet of Lot 2 in Block "B" in Miller Dunes Addition to Gary, as per plat thereof, recorded in Plat Book 22, page 51, in the Office of the Recorder of Lake County, Indiana  
Commonly known as 300 S. Jay St. 45-09-05-154-008.000-004

2. Gloria C. Witham and Ernest F. Witham were husband and wife at the time of acquiring title to the above land and remained so until Gloria. C. Witham's death.

Affiant says nothing further.

*Christine Keller*  
CHRISTINE KELLER,

**Document is NOT VERIFICATION!**

This Document is the property of the Lake County Recorder!

I affirm that the above statements are true.  
*Christine Keller*  
CHRISTINE KELLER

**STOP FILED**

MAR 19 2010



PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

State of Wisconsin  
County of Dane  
This 11<sup>th</sup> day of March, 2010  
Janis I. Wegner  
Janis I. Wegner

My Commission expires 03-13-2011

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LAKE COUNTY RECORDER

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\* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.\*

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No. 06-0597

State No. ....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED - NAME (First, Middle, Last) Gloria C. Witham		2. SEX Female		3a. TIME OF DEATH 2:01 am		3b. DATE OF DEATH (Month, Day, Yr.) November 7, 2006	
4. SOCIAL SECURITY NUMBER [REDACTED] 3119		5a. AGE - Last Birthday (Years) 85		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:	
6a. WAS DECEDENT A U.S. VETERAN? No		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---		6. DATE OF BIRTH (Mo., Day, Yr.) October 14, 1921		7. BIRTHPLACE (City and State or Foreign Country) Gilmanton Wisconsin	
8a. FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake Campus				8b. CITY, TOWN, OR LOCATION OF DEATH Gary		8c. COUNTY OF DEATH Lake	
9. MARITAL STATUS (Specify) Married		10. SURVIVING SPOUSE (If wife, give maiden name) Ernest F. Witham		11. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Homemaker		12. KIND OF BUSINESS/INDUSTRY At Home	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Gary		13d. STREET AND NUMBER 300 Jay Street	
13e. ZIP CODE 46403		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
16. FATHER'S NAME (First, Middle, Last) Frank Krampeter		17. MOTHER'S NAME (First, Middle, Maiden Surname) Belle Landry		18. 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+) N/A	
20a. INFORMANT'S NAME (Type/Print) Ernest F. Witham		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Jay Street, Gary, IN 46403		20c. Relationship Husband			
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) November 10, 2006 NW Indiana Cremation Service		21c. LOCATION - City or Town, State Crown Point, Indiana			
22a. EMBALMER'S NAME James F. Burns		22b. EMBALMER'S LICENSE NO. 01009461		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-			
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SEPTICEMIA DUE TO (OR AS A CONSEQUENCE OF): b. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. ACUTE MYELOID LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): d. Conditions, if any, which gave rise to the immediate cause stating the underlying cause last				Approximate interval between Onset and Death 1 DAY 1 DAY 2 WKS			
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I MYELO DYSPLASTIC SYNDROME				27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) No		28a. WAS AN AUTOPSY PERFORMED? (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>RH Barai</i>		29c. MEDICAL LICENSE NO. 01030107		29d. DATE SIGNED (Month, Day, Year) 11-7-06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Bharat Barai MD 200 E, 89th Avenue, Suite 2A, Merrillville, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>RH Barai</i>						32. DATE FILED (Month, Day, Year) NOV 08 2006	
33. MANNER OF DEATH <input checked="" 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) November 7, 2006				34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.			