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AFFIDAVIT

2012 040741

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Tax I.D. No. 45-07-33-228-004.000-026

SUSAN C. RAE, being first duly sworn upon oath, depose and says:

1. That **JAMES RAE**, died on the 30th day of August, 2003 at, Lake County, Indiana and **CATHERINE RAE a/k/a CATHERINE T. RAE**, died on the 9th day of December, 2011, in Lake County, Indiana.

2. That at the time of their death, they held a Life Estate interest in the following described real estate:
LOT 49 IN LAKESIDE 2ND ADDITION TO THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 36 PAGE 53, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

2012 JUN 20 PM 2:41
MICHAEL B. BROWNING
RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

3. That no Federal Estate Tax or Indiana Inheritance Tax is due as a result of the deaths of James Rae and Catherine Rae a/k/a Catherine T. Rae.

4. That this Affiant's relationship to the Decedent was daughter.

FURTHER, Affiant saith naught.

Susan Rae
Susan C. Rae

Subscribed and sworn to before me, a Notary Public this 7 day of June, 2012.

, Notary Public

My Commission Expires:
County of Residence:

ELIZABETH R. KINZIE
Lake County
My Commission Expires
May 9, 2017

FILED

JUN 15 2012

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

23841

COMMUNITY TITLE COMPANY
FILE NO 122385

#18
CM
CK
NON
comf

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.

Signature of Preparer

Name of Preparer

This instrument prepared by PATRICK J. McMANAMA, Attorney-at-Law, Attorney ID No. 9534-45.
No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 003826 EDR No 000000233341 State No 054408

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Name (If female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
CATHERINE T RAE	TOAL	FEMALE	09:05 AM	12/09/2011

5. Social Security Number	6a. Age - Yrs	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year)	8. Birthplace (City and State or Foreign Country)
[redacted]	82					01/09/1929	MILNGAVIE, ST

9. Ever in U.S. Armed Forces?	10. If Death Occurred In A Hospital:	10a. If Death Occurred Somewhere Other Than A Hospital
☐ Yes ☒ No ☐ Unknown	☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead on Arrival	☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street and Number): 3020 98TH STREET WEST

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
HIGHLAND, IN, 46322	LAKE	☐ Married ☐ Married, But Separated ☐ Divorced ☒ Widowed ☐ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife)Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
		HOMEMAKER	OWN HOME

18. Residence - State	18a. County	18b. City Or Town
INDIANA	LAKE	HIGHLAND

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
3020 98TH STREET WEST		46322	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
HIGH SCHOOL GRADUATE OR GED COMPLETED	NOT HISPANIC	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
ANDREW TOAL	SARAH TOAL	MCCANN

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
SUSAN C RAE	DAUGHTER	7934 GORDON PLACE, HIGHLAND, IN 46322

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location - City, Town, And State
☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	CHAPEL LAWN MEMORIAL GARDENS	SCHERERVILLE, IN

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☒ Yes ☐ No	KUIPER FUNERAL HOME, 9039 KLEINMAN ROAD, HIGHLAND, IN 46322	FH10300021

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
CORNELIUS KUIPER , BY ELECTRONIC SIGNATURE	FD01014511

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additinal Lines If Necessary.

			Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. NATURAL CAUSES	Due to (Or As A Consequence Of):	DAY$
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last	B.	Due to (Or As A Consequence Of):	
	C.	Due to (Or As A Consequence Of):	
	D.		

Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Givin In Part I

DEMENTIA, GASTRIC CANCER, CHRONIC LUNG DISEASE

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Finding Available To Complete The Cause Of Death? ☐ Yes ☐ No

31. Did Tobacoo Use Contribute To Death?	32. If Female:	33. Manner Of Death:
☐ Yes ☐ Probably ☒ No ☐ Unknown	☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 year Before Death ☐ Unknown If Pregnant Within The Past Year	☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:	42. Certifier (Check Only One)
STEVEN A. CORSE , BY ELECTRONIC SIGNATURE	☒ Certifying Physician ☐ Coroner ☐ Heath Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
STEVEN A. CORSE , 3100 45TH AVENUE, HIGHLAND, IN 46322	02000686A	12/13/2011

46. Additional Funeral Service Provider:	47. *Akas:

48. Signature of Local Health Officer:	49. For Registrar Only - Date Filed (Month/Day/Year):
SUSAN W. BEST, VIA ELECTRONIC SIGNATURE	DEC 13 2011

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

Local No. 2071-03
64204

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): James Rae

2 SEX: Male

3a TIME OF DEATH: 12:53P M

3b DATE OF DEATH (Month, Day, Yr): August 30, 2003

4. *SOCIAL SECURITY NUMBER: [redacted]

5a AGE—Last Birthday (Years): 75

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6. DATE OF BIRTH (Mo, Day, Yr): May 23, 1928

7. BIRTHPLACE (City and State or Foreign Country): Scotland

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: [X] Inpatient [ ] ER/Outpatient [ ] DOA
OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy Healthcare

9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer

9d. COUNTY OF DEATH: Lake

10. MARITAL STATUS (Specify): Married

11. SURVIVING SPOUSE (If wife, give maiden name): Catherine Toal

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Sales

12b. KIND OF BUSINESS/INDUSTRY: Pepsi-Cola

13a. RESIDENCE—STATE: IN

13b. COUNTY: Lake

13c. CITY, TOWN, OR LOCATION: Highland

13d. STREET AND NUMBER: 3020 98th St. W

13e. ZIP CODE: 46322

13f. INSIDE CITY LIMITS: [ ] No [X] Yes

13g. ON A FARM? [X] No [ ] Yes

14. CITIZEN OF WHAT COUNTRY? U.S.A.

15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): James Rae

19. MOTHER'S NAME (First, Middle, Maiden Surname): Mulgrew

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Catherine Rae

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3020 98th St. W Highland, IN 46322

20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 3, 2003
Chapel Lawn Memorial Gardens

21c. LOCATION—City or Town, State: Schererville, IN

22a. EMBALMER'S NAME: John T. Noble

22b. EMBALMER'S LICENSE NO.: 9000031

23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR

24b. LICENSE NUMBER (of Licensee): 1021590

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968
8415 Calumet Munster, IN 46321

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — Approximate Interval Between Onset and Death: HRS
DUE TO (OR AS A CONSEQUENCE OF)
b. PARKINSONISM. — Approximate Interval Between Onset and Death: yrs
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: Renal failure

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): ---

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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: X

29c. MEDICAL LICENSE NO.: 01061120

29d. DATE SIGNED (Month, Day, Year): Sept. 3, 2003

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Merz 761 45th Ave. #103 Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: D.O.

32. DATE FILED (Month, Day, Year): September 4, 2003

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)