

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:
Tax I.D. No. 45-07-21-278-009.000-026

2013 052750

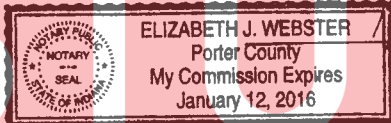
KAREN SUE STEIN, being first duly sworn upon oath, deposes and says:

- 1. That VIRGENE E. BALBO died on the 1st day of December, 2011 at Regency Hospital of Northwest Indiana, in Lake County, Indiana.
2. That at the time of her death, she held a Life Estate interest in the following described real estate:
LOT 32 IN HIGHLAND TERRACE FIFTH ADDITION, TO THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 30 PAGE 19 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
3. That no Federal Estate Tax or Indiana Inheritance Tax is due as a result of the death of VIRGENE E. BALBO.
4. That this Affiant's relationship to the Decedent was daughter.

FURTHER, Affiant saith naught.

This Document is the property of KAREN SUE STEIN the Lake County Recorder!

Subscribed and sworn to before me, a Notary Public this 8th day of July, 2013.



My Commission Expires:
County of Residence:

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 ELIZABETH J WEBSTER

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.

FILED JUL 15 2013

PEGGY HOLLINGA KATONA LAKE COUNTY AUDITOR

COMMUNITY TITLE COMPANY FILE NO 134297 13694

STATE OF INDIANA LAKE COUNTY RECORDER MICHAEL J. JOHNSON 2013 JUL 15 AM 10:36 FILED FOR RECORD

\$14 CM CA NON CONF



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

721748

Local No 000258

EDR No 00000232429

State No

| | | | | | | | | | | |
|---|----------------------------|---|---|---|---|--|--|---|----------------------|--|
| 1. Decedent's Legal Name (First, Middle, Last) VIRGENE E BALBO | | | | 1a. Maiden Name (if female) DELLENBACH | | 2. Sex FEMALE | 3. Time Of Death 07:45 AM | 4. Date Of Death (Month/Day/Year) 12/01/2011 | | |
| 5. Social Security Number 315-30-8831 | 6a. Age - Yrs 81 | 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) 05/09/1930 | | 8. Birthplace (City and State or Foreign Country) HAMMOND, IN | | |
| 9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival | | | 10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify) | | | | | |
| 11. Facility Name (If Not Institution, Give Street and Number) REGENCY HOSPITAL OF NORTHWEST INDIANA, LLC | | | | | | | | | | |
| 12. City Or Town, State, And Zip Code EAST CHICAGO, IN, 46312 | | | | 13. County Of Death LAKE | | | 14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | | |
| 15. Surviving Spouse's Name | | | 15a. (If Wife) Give Maiden Last Name | | | 16. Decedent's Usual Occupation HOMEMAKER | | 17. Kind Of Business/Industry OWN HOME | | |
| 18. Residence - State INDIANA | | 18a. County LAKE | | 18b. City Or Town HIGHLAND | | | | | | |
| 18c. Street And Number 8407 5TH PLACE | | | | 18d. Apt. No. | | 18e. Zip Code 46322 | | 18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED | | | 20. Decedent Of Hispanic Origin NOT HISPANIC | | | 21. Decedent's Race White | | | | |
| 22. Father's Name (First, Middle, Last) EDWARD C DELLENBACH | | | 23. Mother's Name (First, Middle, Last) ELIZABETH DELLENBACH | | | 23a. Mother's Maiden Last Name MAYER | | | | |
| 24. Informant's Name KAREN S STEIN | | 24a. Relationship To Decedent DAUGHTER | | 24b. Mailing Address (Street And Number, City, State, Zip Code) 14602 93TH LANE, DYER, IN 46311 | | | | | | |
| 25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify): | | | 25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) CHapel LAWN MEMORIAL GARDENS | | | 25c. Location - City, Town, And State SCHERERVILLE, IN | | | | |
| 25. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 27. Name And Complete Address Of Funeral Facility KUIPER FUNERAL HOME, 9039 KLEINMAN ROAD, HIGHLAND, IN 46322 | | | | | 27a. Funeral Home License Number: FH10300021 | | | |
| 27b. Signature Of Indiana Funeral Service Licensee: CORNELIUS KUIPER, BY ELECTRONIC SIGNATURE | | | | | | 27c. License Number (Of Licensee): FD01014511 | | | | |
| 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 Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. SEPSIS DUE TO ACINETOBACTER/KLEBSIELLA URINARY TRACT INFECTION <small>Due to (Or As A Consequence Of):</small> B. MITRAL VALVE ENDOCARDITIS DUE TO ENTEROBACTER SPECIES <small>Due to (Or As A Consequence Of):</small> C. ISCHEMIC COLITIS <small>Due to (Or As A Consequence Of):</small> D. _____ 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 | | | | | | | | | | |
| Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I | | | | | | 28. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| N/A | | 30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | 33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined | | | | | |
| 31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 32. If Female: <input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 43 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year | | | 37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 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) | | | 38. Location Of Injury - State | | | |
| 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) | | | 38a. City Or Town | | 38b. Street & Number | |
| 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) | | | 38c. Apt. No. | | 38d. Zip Code | |
| 39. Describe How Injury Occurred | | | | | | 40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) | | | | |
| 41. Signature, Of Person Certifying Cause Of Death: JOSEPH C. LEGASPI, BY ELECTRONIC SIGNATURE | | | | | | 42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer | | | | |
| 43. Name, Address And Zip Code Of Person Certifying Cause Of Death: JOSEPH C. LEGASPI, 9307 CALUMET AVE D1, MUNSTER, IN 46321 | | | | | | 44. License Number 01059155A | | 45. Date Certified 12/05/2011 | | |
| 46. Additional Funeral Service Provider: | | | | | | 47. *Akas: | | | | |
| 48. Signature of Local Health Officer: PAULA BENCHIK-ABRINKO, VIA ELECTRONIC SIGNATURE | | | | | | 49. For Registrar Only - Date Filed (Month/Day/Year): DEC 06 2011 | | | | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | | | | | | | | | |