# SATISFACTION OF MORTGAGE

**THIS CERTIFIES,** that a certain Mortgage executed by JOSEPH M. FOSTER and HELEN M. FOSTER, husband and wife, to GEORGE W. HACKER recorded on DECEMBER 13, 1983 as **Document Number 737325** in regards to real property legally described as follows:

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2014 MAY -2 AM 8:31
MICHAEL B. BROWN
RECORDER

Lot Three Hundred Seventy-Four Southtown Estates 8th Addition To the Town of Highland, Lake County, Indiana, as shown in Plat Book 35, page 13, in Lake County, Indiana.

**Commonly Known As: 3509 – 42nd Place, Highland, IN 46322**
**Parcel #: 45-07-27-328-034.000-026**

has been fully paid and satisfied, and the same is hereby **RELEASED**.

WITNESS my hand and seal, this 1st day of May, 2014.

2014 024631

By: Arlene Hacker
**ARLENE HACKER, surviving spouse of George W. Hacker**



STATE OF INDIANA )
)
COUNTY OF LAKE )

BEFORE ME, the undersigned, a Notary Public, personally appeared Arlene Hacker and acknowledged the execution of this instrument, this 1st day of May, 2014.

My commission expires: May 25, 2018
County of Residence: Lake

Beth A. Taguc
Notary Public

Beth A. Taguc
Printed Name

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.

Randy H. Wyllie, Attorney

This instrument prepared by: Randy H. Wyllie, Esq., Wieser & Wyllie, LLP, 429 West Lincoln Highway, Schererville, Indiana 46375; (219) 865-7404

AMOUNT $ 15
CASH ____ CHARGE ____
CHECK # 3791
OVERAGE ____
COPY ____
NON-COM X
CLERK CM

12 CC & 3VET

# INDIANA STATE BOARD OF HEALTH

Local No. 3003-89 — **CERTIFICATE OF DEATH** — State No. .....

**TYPE/PRINT IN PERMANENT BLACK INK**

**DECEDENT**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED—NAME: FIRST | MIDDLE | LAST | 2. SEX | 3. DATE OF DEATH (Mo., Day, Yr.) | |
| GEORGE | W. | HACKER | MALE | JUNE 3, 1989 | |
| 4. SOCIAL SECURITY NUMBER | 5a. AGE—Last Birthday (Years) | 5b. UNDER 1 YEAR: Months / Days | 5c. UNDER 1 DAY: Hours / Minutes | 6. DATE OF BIRTH (Month, Day, Year) | 7. BIRTHPLACE (City and State or Foreign Country) |
| [redacted]6 | 64 | | | MAY 20, 1925 | CALUMET CITY, ILLINOIS |
| 8. YEAR LAST SERVED IN U.S. ARMED FORCES | 9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA | OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify) | | | |
| YES WW II | | | | | |
| 9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH | | | |
| ST. ANTHONY MEDICAL CENTER | CROWN POINT | LAKE | | | |
| 10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 12b. KIND OF BUSINESS/INDUSTRY | | |
| MARRIED | ARLENE M. HUDSON | RETIRED BOILER MAKER | U.S. STEEL CORP. | | |
| 13a. RESIDENCE—STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER | | |
| INDIANA | LAKE | HEBRON | 17810 UNION STREET | | |
| 13e. INSIDE CITY LIMITS? (Yes or no) | 13f. FARM | 13g. ZIP CODE | 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify: | 15. RACE—American Indian, Black, White, etc. (Specify) | 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+) |
| YES | NO | 46341 | | WHITE | 8 |
| **PARENTS** 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| FRED HACKER | | META LINDNER | | | |
| **INFORMANT** 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 19c. Relationship | | | |
| ARLENE HACKER | 17810 UNION ST. HEBRON, IN 46341 | WIFE | | | |
| **DISPOSITION** 20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) | 20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 20c. LOCATION—City or Town, State | | | |
| | JUNE 6, 1989 CHAPEL LAWN MEMORIAL GARDENS | SCHERERVILLE, INDIANA | | | |
| 21a. SIGNATURE OF FUNERAL DIRECTOR | 21b. LICENSE NUMBER (of Licensee) | 22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME | | | |
| James F. Burns | 1013890 | BURNS FUNERAL HOME FDH: 8600018 10101 BROADWAY CROWN POINT, IN 46307 | | | |

**PRONOUNCING PHYSICIAN ONLY**

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

| 23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title | 23b. LICENSE NUMBER | 23c. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | 2020 709 | 6/6/89 |
| 24. TIME OF DEATH | 25. DATE PRONOUNCED DEAD (Month, Day, Year) | 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) |
| 10 37 AM | 6/6/89 | NO |

**CAUSE OF DEATH** — SEE INSTRUCTIONS

27. PART I. Enter the disease, injury, or complication that caused the death. Do not enter the mode of dying, 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. | severe Congestive Cardiac Failure |
| DUE TO (OR AS A CONSEQUENCE OF) b. | arteriosclerotic heart disease |
| DUE TO (OR AS A CONSEQUENCE OF) c. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF) d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive lung disease

28a. AUTOPSY PERFORMED? (Yes or no) — 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

AUTOPSY DEATH ON FILE HEALTH DEPT. — NO

THIS CERTIFIES THE ABOVE INFORMATION AND A TRUE COPY OF AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

**SEE INSTRUCTIONS**

**CERTIFIER**

29a. CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. — JUN 7 1989

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronounced death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner stated.

Ronald Johnson MD — LAKE COUNTY HEALTH COMMISSIONER

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | IN 25043 | 6/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DR. KRISHNAN BOTTI, M.D. 8300 BROADWAY MERRILLVILLE, INDIANA 46410

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE: Ronald Johnson MD — 32. DATE FILED (Month, Day, Year): June 7, 1989

**CORONER OR MEDICAL EXAMINER 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)

SBH08-004 State Form 10110 (R/10-87) DEATH A/PD 1