

3.

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2015 070376

2015 OCT 16 AM 10:02

AFFIDAVIT

MICHAEL B. BROWN  
RECORDER

On this 9/28/2015 before me personally appeared Rebecca A. Siegfried  
(insert date)

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is Daughter  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said Oleta Walls  
(fill in name of life estate tenant who died)  
died on December 16, 1996

4. The legal description of the premises in question is:  
Lot 74, Liberty Park Highlands, an Addition to the City of Crown Point  
Indiana, as per plat thereof, recorded in Plat Book 25, Page 8, in  
the Office of the Recorder of Lake County, Indiana.

45-10-05-101-013-000-042

5. Is there Federal or State inheritance tax liability by reason of the death of said  
decedent?  Yes  No

If yes, then estimated taxes due are \$ \_\_\_\_\_

The taxes due are  paid or  unpaid..

6. Affiant states that Oleta Walls continued to live and cohabit as  
husband and wife continuously from the date she and William W. Walls  
took title to the above real estate, until the date of Oleta Walls  
death.

7. Affiant's relationship to the deceased was daughter

**FIDELITY NATIONAL  
TITLE COMPANY**

92015-2167

\$15.00  
M.E  
FW

22257

**FILED**

OCT 09 2015

**JOHN E. PETALAS  
LAKE COUNTY AUDITOR**

Signature: Rebecca A. Siegfried  
Printed Name Rebecca A. Siegfried  
Address: 304 Cedar St.  
Crown Point, IN 46307

Subscribed and sworn to before me by the affiant

This 9/28/15  
(insert date)

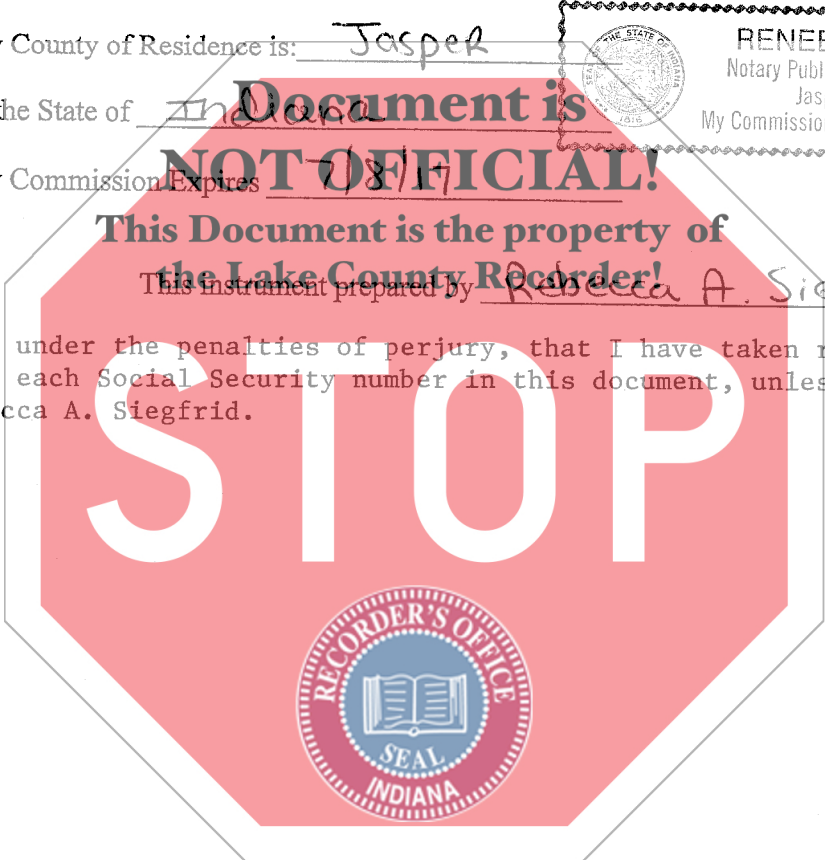
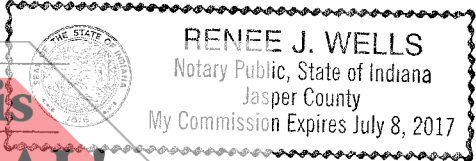
[Signature]  
Notary Public

Printed Name Renee J. Wells

My County of Residence is: Jasper

In the State of Indiana

My Commission Expires 7/8/17



I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law, Rebecca A. Siegfried.



\* 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

Local No. 3453-96

State No.

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

41523 TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Oleta Walls		2. SEX Female	3a. TIME OF DEATH 9:50PM	3b. DATE OF DEATH (Month, Day, Yr.) December 16, 1996
4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years) 74	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) SEP 18, 1922
7. BIRTHPLACE (City and State or Foreign Country) Cleaton, KY	8a. WAS DECEASED A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) 304 Cedar		9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) William Walls	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Bookkeeper/Head Cashier	12b. KIND OF BUSINESS/INDUSTRY Grocery Store	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Crown Point	13d. STREET AND NUMBER 304 Cedar	
13e. ZIP CODE 46307	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEASED OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) White
17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		18. FATHER'S NAME (First, Middle, Last) Albert Atlas		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Allison Maude Bell Keeling		20a. INFORMANT'S NAME (Type/Print) William Walls		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Cedar, Crown Point, IN 46307		20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input 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) DEC 20, 1996 Rose Hill Cemetery		21c. LOCATION—City or Town, State Central City, KY
22a. EMBALMER'S NAME Larry A. Geisen		22b. EMBALMER'S LICENSE NO. FD09000013	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD09000013	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN 46307 FH83001253	
26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. Only one cause on each line. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HEALTH DEPT. IMMEDIATE CAUSE OF DEATH (DUE TO OR AS A CONSEQUENCE OF): a. <u>Cardiac Arrest</u> b. <u>brain tumor</u> c. <u>DEC 18 1996</u> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <i>[Signature]</i> LAKE COUNTY HEALTH COMMISSIONER		Approximate Interval Between Onset and Death		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/> No	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/> No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/> No
29a. CERTIFIER (Check only one) <input 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>[Signature]</i>		
29c. MEDICAL LICENSE NO. 010359c6		29d. DATE SIGNED (Month, Day, Year) 12/31/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Hytham Rifai MD, 103 E. 89th Ave., Merrillville, IN 46410				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) December 17, 1996		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				

