3.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 070376

2015 OCT 16 AM 10:02

MICHAEL B. BROWN
RECORDER

AFFIDAVIT

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

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.

45-10-05-101-018.000-042

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
MC
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)

Notary Public

Printed Name Renee J. Wells

My County of Residence is: Jasper

In the State of Indiana

My Commission Expires 7/8/17

RENEE J. WELLS
Notary Public, State of Indiana
Jasper County
My Commission Expires July 8, 2017

This instrument prepared by Rebecca A. Siegfried

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. Siegfrid.

* **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. .....

41523

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Oleta		Walls	Female	9:50PM	December 16, 1996

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 (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
	74			SEP 18, 1922	Cleaton, KY

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
No	N/A	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
304 Cedar	Crown Point	Lake

10. MARITAL STATUS (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	William Walls	Bookkeeper/Head Cashier	Grocery Store

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Crown Point	304 Cedar

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46307	☐ No ☒ Yes	☒ No ☐ Yes	USA	☐ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)			19. MOTHER'S NAME (First, Middle, Maiden Surname)		
Albert	Atlas	Allison	Maude	Bell	Keeling

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
William Walls	304 Cedar, Crown Point, IN 46307	Husband

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	DEC 20, 1996 Rose Hill Cemetery	Central City, KY

22a. EMBALMER'S NAME:	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?	24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Larry A. Geisen	FD09000013	☒ No ☐ Yes	[signature]	FD09000013	FH83001253 Geisen Funeral Home, Inc. 109 N East St., Crown Point, IN46307

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. brain tumor	
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.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No

CERTIFIER

29a. CERTIFIER (Check only one)

☐ 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	010359C6	12/31/96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Hytham Rifai M.D., 103 E. 89th Ave., Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE [signature] M.D.

32. DATE FILED (Month, Day, Year) December 17, 1996

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.