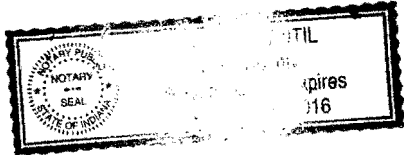


stated that the facts alleged therein are true.

Witness my hand and Notarial Seal this 23rd day of February, 2016.

Lauren Vantil

Signature of Notary Public

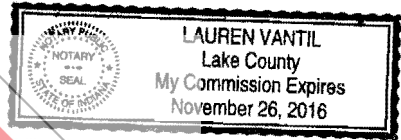


Lauren Vantil

Printed Name of Notary Public

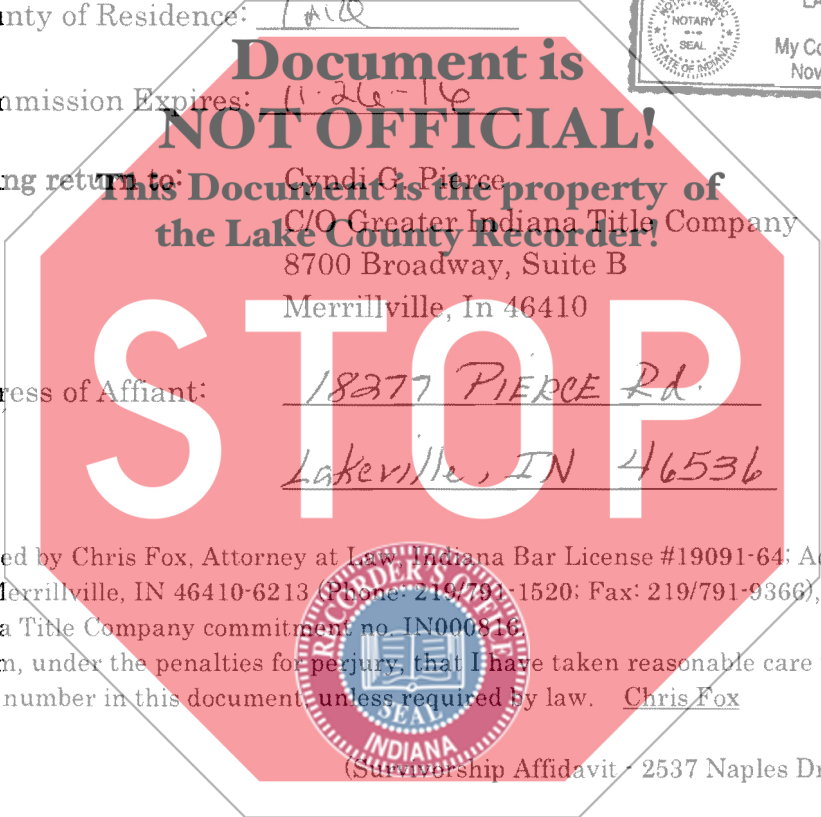
Notary's County of Residence: Lake

Notary's Commission Expires: 11-26-16



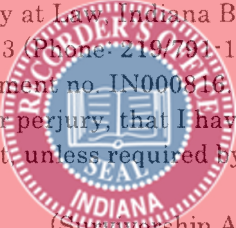
After recording return to: Cyndi G. Pierce
C/O Greater Indiana Title Company
8700 Broadway, Suite B
Merrillville, In 46410

Mailing Address of Affiant: 18377 PIERCE RD.
Lakeville, IN 46536



Prepared by Chris Fox, Attorney at Law, Indiana Bar License #19091-64; Address: 516 East 86th Avenue, Merrillville, IN 46410-6213 (Phone: 219/791-1520; Fax: 219/791-9366), referencing Greater Indiana Title Company commitment no. IN000816

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. Chris Fox





INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Tracking No. 52580

Local No 001513

EDR No 00000446048

State No 021312

1. Decedent's Legal Name (First, Middle, Last) RAYMOND H KRAGER				1a. Maiden Name (If female)		2. Sex MALE	3. Time Of Death 11:17 PM	4. Date Of Death (Month/Day/Year) 04/27/2015	
5. Social Security Number [REDACTED]	6a. Age - Yrs 92	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) 12/10/1922		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) COMMUNITY HOSPITAL									
12. City Or Town, State, And Zip Code MUNSTER, IN, 46321					13. County Of Death LAKE		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name DORIS M KRAGER			15a. (If Wife) Give Maiden Last Name YERGA			16. Decedent's Usual Occupation SALES REPRESENTATIVE		17. Kind Of Business/Industry WHOLESALE FOOD DISTRIBUTER	
18. Residence - State INDIANA		18a. County LAKE			18b. City Or Town SCHERERVILLE		18d. Apt. No.	18e. Zip Code 46375	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
18c. Street And Number 2537 NAPLES DRIVE		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) VERNON KRAGER				23. Mother's Name (First, Middle, Last) GRACE KRAGER			23a. Mother's Maiden Last Name SCHMIDT		
24. Informant's Name DORIS M KRAGER		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 2537 NAPLES DRIVE, SCHERERVILLE, IN 46375					
25. Place Of Disposition									
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) CATHOLIC CEMETERIES				25c. Location - City, Town, And State HAMMOND, IN			
26. 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: DAVID R. PETERSON, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee): FD08601585			
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. HOSPICE CARE Due to (Or As A Consequence Of) DUE TO									
B. ACUTE RESPIRATORY FAILURE Due to (Or As A Consequence Of) DUE TO									
C. CHRONIC RESPIRATORY FAILURE Due to (Or As A Consequence Of)									
D.									
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I									
FAILURE TO THRIVE									
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" 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 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Time Of Death				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			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number 2537 NAPLES DRIVE		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			
41. Signature, Of Person Certifying Cause Of Death: KHALED A REHEEM-FARAG, 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: KHALED A REHEEM-FARAG, 7330 INDIANAPOLIS BLVD., HAMMOND, IN 46324						44. License Number 01059379A		45. Date Certified 05/03/2015	
46. Additional Funeral Service Provider:						47. *As:			
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): MAY 04 2015			
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)									

