

2016 039447

2016 JUN 27 AM 10:12

MICHAEL B. BROWN  
RECORDER

**AFFIDAVIT of SURVIVORSHIP**

Tax: I.D. NO. 45-07-35-103-021.000-006

*AKA MARY J Brady*  
**MARY JEAN BRADY**, being first duly sworn upon oath, deposes and says:

1. That **ROBERT JOHN BRADY A/K/A ROBERT BRADY**, *AKA Robert J Brady* died on the 19th day of July, 1997 at Indianapolis, Marion County, Indiana.

2. That at the time of his death, he was co-owner as Joint Tenant with Mary Jean Brady in the following described real estate:

**LOT 1 IN BRADY'S ADDITION TO THE TOWN OF GRIFFITH AS PER PLAT THEREON RECORDED IN PLAT BOOK 92, PAGE 6, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.**

Commonly known as: **717 N HARVEY STREET, GRIFFITH IN 46319**

3. That no Federal Estate Tax or Indiana Inheritance Tax is due as a result of the death of Robert John Brady a/k/a Robert Brady.

4. That this Affiant's relationship to the Decedent was Husband.

**FURTHER**, your Affiant saith naught.

*Mary Jean Brady*  
\_\_\_\_\_  
**MARY JEAN BRADY**

STATE OF INDIANA, COUNTY OF Lake SS: \_\_\_\_\_

Before me, the undersigned, a Notary Public in and for said county and state this 17 day of June, 2016, personally appeared **ROBERT JOHN BRADY A/K/A ROBERT BRADY**, and acknowledged the execution of the foregoing Affidavit. In witness whereof, I have hereunto subscribed my name and affixed my official seal.

My Commission Expires: 5/9/17 Signature [Signature]  
County of Residence: Lake Printed \_\_\_\_\_, Notary Public

This instrument prepared by **MATTHEW W. DEULLEY**, Attorney-at-Law, ID No. 27813-45

No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

**ELIZABETH R. KINZIE**  
Lake County  
My Commission Expires  
May 9, 2017

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] Elizabeth Kinzie  
Signature of Preparer Notary Public Name of Preparer

**JOHN E. PETALAS**  
LAKE COUNTY AUDITOR

003694

COMMUNITY TITLE COMPANY  
FILE NO 1610126



ISSUED BY MARION COUNTY HEALTH DEPARTMENT

ON ESTATE: Disclosure of the need to pursue our responsibilities and there will be no penalty for

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

PRINT  
INK  
NOT VALID UNLESS MACHINE-NUMBERED AND SIGNED WITH MULTICOLOR RIBBON ON THE REVERSE SIDE.

1. DECEASED—NAME (First, Middle, Last) <b>Robert Bracy</b>		2. SEX <b>male</b>	3a. TIME OF DEATH <b>1048 A M</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>July 19, 1997</b>	
4. SOCIAL SECURITY NUMBER <del>XXXXXXXX</del>	5a. AGE—Last Birthday (Years) <b>61</b>	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) <b>August 30, 1935</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Evanston, Illinois</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1965</b>	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>	9c. CITY, TOWN, OR LOCATION OF DEATH <b>Indianapolis</b>	9d. COUNTY OF DEATH <b>Marion</b>			
10. MARITAL STATUS (Specify) <b>married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Mary Jean Markwalder</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Claims Supervisor</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Insurance Co.</b>		
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Griffith</b>	13d. STREET AND NUMBER <b>708 N. Harvey St.</b>		
13e. ZIP CODE <b>46319</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (Specify: Mexican, Puerto Rican, etc.)	16. RACE—American Indian, White, etc. (Specify) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>	18. FATHER'S NAME (First, Middle, Last) <b>John Brady</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname)		
20a. INFORMANT'S NAME (Type/Print) <b>Mary Jean Brady</b>	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>708 N. Harvey St. Griffith, IN 46319</b>	20c. Relationship <b>Wife</b>			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) <b>July 23, 1997 Mount Mercy Cemetery</b>	21c. LOCATION—City or Town, State <b>Calumet Twp. Indiana</b>			
22a. EMBALMER'S NAME <b>Jeffery A. Bell</b>	22b. EMBALMER'S LICENSE NO. <b>FD08800290</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <b>Ronald A. Reed</b>	24b. LICENSE NUMBER (of Licensee) <b>FD01001081</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: <b>Kuiper Funeral Home EB8300-7500 9039 Kleinman Rd. Highland, IN 46322</b>			
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. List only one cause on each line.				Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Transplantation rejection</b>					
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. <b>pulmonary Hypertension</b>					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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 <b>Michelle Lewis MD</b>			
29c. MEDICAL LICENSE NO. <b>01045355</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/19/97</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Michelle Lewis 550 Univ Blvd Indianapolis, IN 46202</b>					
31. HEALTH OFFICERS SIGNATURE <b>Virginia A. Caine, MD</b>				32. DATE FILED (Month, Day, Year) <b>JUL 24 1997</b>	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		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.			

