

4

~~BA1710090~~ CTNW1700239



Chicago Title Insurance Company

2017 049807

AFFIDAVIT

On this 26th day of July before me personally appeared _____

Kathleen Hansen

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

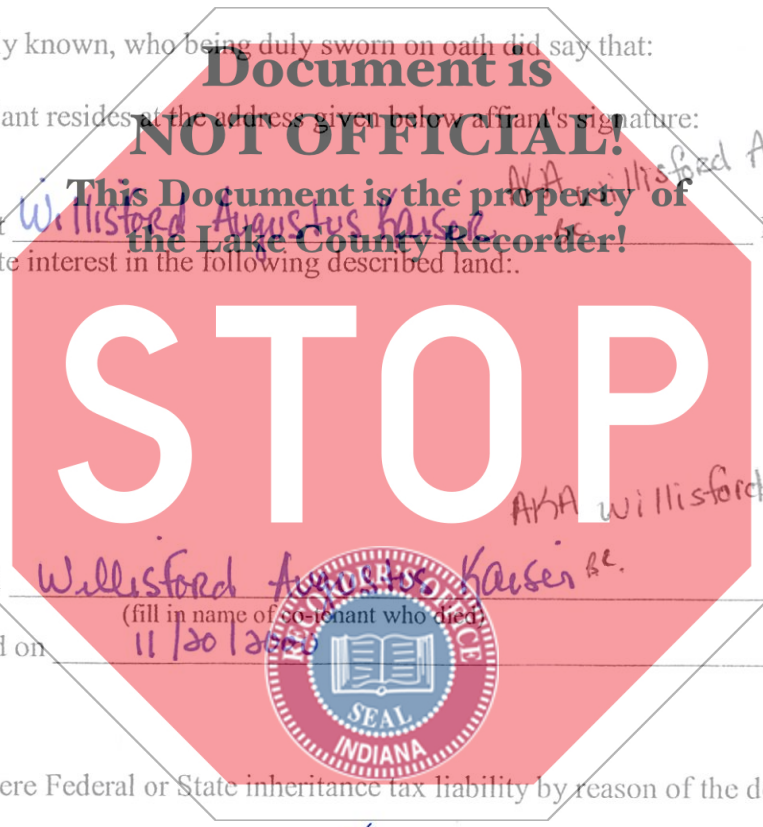
1. Affiant resides at the address given below affiant's signature:
2. That W. Williford Augustus Kaiser held a life estate interest in the following described land:.

3. Said Williford Augustus Kaiser died on 11/20/2011

4. 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..



CHICAGO TITLE INSURANCE COMPANY

MICHAEL B. BROWN
RECORDER

2017 AUG -9 AM 11:53

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

AKA Williford A. Kaiser



FILED

AUG 07 2017

JOHN E. PETALAS
LAKE COUNTY AUDITOR

031319

\$25,000

JAS

CH 1820503577

5. Affiant's relationship to the deceased was Daughter

Signature: Kathleen Hansen

Printed Name Kathleen Hansen

Address: _____

Subscribed and sworn to before me by the affiant

This 7/26/17
(insert date)

Kathleen
Notary Public

Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!
Notary Public



Printed Name _____

My County of Residence is: _____

In the State of _____

My Commission Expires _____



This instrument prepared by Kathleen Hansen



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 KA

LEGAL DESCRIPTION

Order No.: CTNW1700239

133 Park Manor Dr. Dyer, IN. 46311-2138

For APN/Parcel ID(s): 45-10-13-176-008.000-034

LOT 4 (EXCEPT THE WEST 39.3 FEET THEREOF), BLOCK 2, PLUM CREEK ADDITION; ALSO PART OF THE SOUTH 1/2 OF THE NORTHWEST 1.4 OF SECTION 13, TOWNSHIP 35 NORTH, RANGE 10 WEST OF THE 2ND P.M. DESCRIBED AS FOLLOWS; BEGINNING AT THE NORTHEAST CORNER OF SAID LOT 4, BLOCK 2, PLUM CREEK ADDITION AND RUNNING THENCE NORTH ON THE EAST LINE OF SAID LOT 4 EXTENDED NORTH, 83 FEET TO A POINT ON THE SOUTH LINE OF LOT 3, PLUM CREEK ANNEX EXTENDED EAST; THENCE WEST ON SAID SOUTH LINE OF LOT 3 EXTENDED AND ON THE SOUTH LINE OF SAID LOT 3, 80.7 FEET; THENCE SOUTH 82.58 FEET TO A POINT ON THE NORTH LINE OF SAID LOT 4, BLOCK 2, PLUM CREEK ADDITION, WHICH POINT IS 39.3 FEET EAST OF THE NORTHWEST CORNER OF SAID LOT 4; THENCE EAST ; ON SAID NORTH LINE OF LOT 4, 80.7 FEET TO THE PLACE OF BEGINNING, ALL IN THE TOWN OF DYER, LAKE COUNTY, INDIANA, CONTAINING IN ALL 0.422 ACRES, MORE OR LESS.



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

State No.

Local No. 2698-00

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

PRECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <u>Willisford Augustus Kaiser</u>		2 SEX <u>Male</u>	3a. TIME OF DEATH <u>3:35 P M</u>	3b. DATE OF DEATH (Month, Day, Yr.) <u>November 20, 2000</u>	
4 *SOCIAL SECURITY NUMBER <u>[REDACTED]</u>	5a AGE—Last Birthday (Years) <u>78</u>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <u>October 3, 1922</u>	
7. BIRTHPLACE (City and State or Foreign Country) <u>Dyer, Indiana</u>	8a. WAS DECEDENT A U.S. VETERAN? <u>Yes</u>				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <u>1945</u>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) <u>Regency Place of Dyer</u>		9c. CITY, TOWN, OR LOCATION OF DEATH <u>Dyer</u>	9d. COUNTY OF DEATH <u>Lake</u>		
10. MARITAL STATUS (Specify) <u>Married</u>	11. SURVIVING SPOUSE (If wife, give maiden name) <u>Anita E. Dahlke</u>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Plant Manager</u>		12b. KIND OF BUSINESS/INDUSTRY <u>Beverage Supply Distribution</u>	
13a. RESIDENCE—STATE <u>Indiana</u>	13b. COUNTY <u>Lake</u>	13c. CITY, TOWN, OR LOCATION <u>Dyer</u>		13d. STREET AND NUMBER <u>133 Park Manor Dr</u>	
13e. ZIP CODE <u>46311</u>	13i. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <u>White</u>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>		<u>College (1-4 or 5 +)</u> <u>12</u>			
18 FATHER'S NAME (First, Middle, Last) <u>Henry Kaiser</u>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <u>Margaret Muenshen</u>			
20a. INFORMANT'S NAME (Type/Print) <u>Anita E. Kaiser</u>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>133 Park Manor Dr Dyer, Indiana 46311</u>		20c. Relationship <u>Wife</u>	
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) <u>November 24, 2000 Chapel Lawn Memorial Gardens</u>		21c. LOCATION—City or Town, State <u>Schererville, Indiana</u>	
22a. EMBALMER'S NAME <u>Henry Blake</u>		22b. EMBALMER'S LICENSE NO. <u>FDO 1019406</u>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <u>Edward F. Mallamy</u>		24b. LICENSE NUMBER (of Licensee) <u>FDO 1007176</u>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <u>Fagen-Miller Funeral Homes Inc 1920 Hart St Dyer, Indiana 46311</u> FH83001504		
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>Colon CA</u> DUE TO (OR AS A CONSEQUENCE OF) b. <u>CAD</u> DUE TO (OR AS A CONSEQUENCE OF) c. <u>CHF</u> DUE TO (OR AS A CONSEQUENCE OF) d. Conditions if any, which gave rise to the immediate cause, stating the underlying cause last		Approximate Interval Between Onset and Death			
PART II Other significant conditions - Conditions contributing to death but not previously stated (4/23/97)		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <u>No</u>	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <u>No</u>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <u>-</u>	
29a. CERTIFIER (Check only one) <input checked="" 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 <u>A. Syemer, M.D.</u>			
29c. MEDICAL LICENSE NO. <u>01025591</u>		29d. DATE SIGNED (Month, Day, Year) <u>11-22-00</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) <u>A. Syemer 761-45th St, Suite 103 Munster, IN 46321</u>					
31. HEALTH OFFICER'S SIGNATURE <u>Daryl H. Tolson, M.D.</u>		32. DATE FILED (Month, Day, Year) <u>November 22, 2000</u>			
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, COUNTY HEALTH DEPT.
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) <u>NOV 22 2000</u>			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

