

NOT AN OFFICIAL DOCUMENT

Decedent, Walter Thomas', name be removed from the above described property and all future tax bills be issued in her name.

FURTHER AFFIANT SAYETH NAUGHT.

Eleanore Thomas
Eleanore Thomas, Affiant

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SUBSCRIBED and SWORN to me, a Notary Public, this 3 day of
June, 2016.

My Commission Expires:

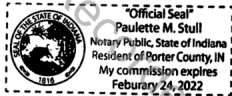
02/24/2022

Paulette M Stull
Notary Public

Paulette M Stull
Notary's Name Printed

Resident of Porter County, State of Indiana

PREPARED BY:
MICHAEL R. STAJEWSKI
ATTORNEY AT LAW



"I AFFIRM, UNDER THE PENALTIES FOR PERJURY THAT I HAVE TAKEN REASONABLE CARE TO PROTECT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW."
PREPARED BY: [Signature]



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INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH - RESUBMIT

Tracking No. 6A737

Local No 002948

EDR No 00000467685

State No 042054

1. Decedent's Legal Name (First, Middle, Last) WALTER D THOMAS		1a. Maiden Name (if female)		2. Sex MALE	3. Time of Death 05:20 AM	4. Date of Death (Month/Day/Year) 09/08/2015	
5. Social Security Number 84		6a. Age - Yrs 84	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) 01/29/1931
8. Birthplace (City and State and Foreign Country) CHICAGO, IL		10. If Death Occurred In A Hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Hospice Facility <input checked="" 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) 3560 SUNRISE DRIVE		12. City Or Town, State, And Zip Code		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"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	
15. Surviving Spouse's Name ELEANORE THOMAS		15a. (if Wife) Give Maiden Last Name MASLOWSKI		16. Decedent's Usual Occupation MAINTENANCE		17. Kind Of Business/Industry MECHANIC	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town CROWN POINT		18d. Apt. No.	18e. Zip Code 46307
18c. Street And Number 3560 SUNRISE DRIVE		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
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) WALTER M THOMAS		23. Mother's Name (First, Middle, Last) ELEANORE THOMAS		23a. Mother's Maiden Last Name THROW			
24. Infomant's Name ELEANORE THOMAS		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 3560 SUNRISE DRIVE, CROWN POINT, IN 46307			
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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) NWI CREMATION SERVICES		25c. Location - City, Town, And State CROWN POINT, IN			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility BURNS FUNERAL HOME (CROWN POINT), 10101 BROADWAY, CROWN POINT, IN 46307		27a. Funeral Home License Number FH83002445			
27b. Signature Of Indiana Funeral Service Licensee JAMES E. BURNS, BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee) FD20700059		Approximate Interval Since To Death			
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.		Cause Of Death (See Instructions And Examples)		Approximate Interval Since To Death			
Immediate Cause (Final Disease Or Condition Resulting In Death)		A. LIVER CANCER		THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT			
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last		B.		SEP 14 2015			
C.		D.		29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Part II. Enter Other Significant Conditions Contributing To Death, But Not Resulting In The Underlying Cause Given In Part I.		30. Were Autopsy Findings Available Or Complete For Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		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			
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 Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year		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 checked="" type="checkbox"/> No			
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		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 <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other <input type="checkbox"/> None			
41. Signature, Of Person Certifying Cause Of Death KATHRYN HENKLE MULLIGAN, BY ELECTRONIC SIGNATURE		42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		44. License Number 01052342A			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death KATHRYN HENKLE MULLIGAN, 919 MAIN STREET, SUITE 102, DYER, IN 46311		45. Date Certified 09/08/2015		46. Additional Funeral Service Provider			
48. Signature of Local Health Officer SUSAN W. BEST, VIA ELECTRONIC SIGNATURE		49. For Registrar Only - Date Filed (Month/Day/Year) SEP 14 2015		AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)			
49: 09/08/2015 22-Last: SMITH		RAISED SEAL AFFIXED					