2024-501695
01/17/2024 02:12 PM
TOTAL FEES: 25.00
BY: JAS
PG #: 3
RECORDED AS PRESENTED

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
GINA PIMENTEL
RECORDER

FILED
Jan 17 2024 LM
PEGGY HOLINGA-KATONA
LAKE COUNTY AUDITOR

AFFIDAVIT OF DEATH

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

On this 12th day of January 2024, before me personally appeared Kerry Mitchell, who being duly sworn on his oath states the following:

1. That the Robert G. Mitchell retained a Life Estate in the real estate located in Lake County, State of Indiana, more particularly described as follows:

THE WESTERLY 37-1/2 FEET OF THE EASTERLY HALF OF LOT 17, IN BLOCK 3, AS MARKED AND LAID DOWN ON THE RECORDED PLAT OF THE REDIVISION OF HELBERG'S OAK RIDGE ADDITION TO THE CITY OF HAMMOND AS SHOWN IN PLAT BOOK 3, PAGE 23, IN LAKE COUNTY, INDIANA.

Parcel No.: 45-03-31-381-046.000-023
Commonly known as: 1155 Summer St., Hammond, IN 46320

2. That said Robert G. Mitchell died on December 13, 1991, a resident of Lake County, Indiana, per the attached Death Certificate as Exhibit A.

FURTHER AFFIANT SAITH NOT.

IN WITNESS WHEREOF, Grantor has executed this Affidavit this 12th day of January 2024.

KERRY MITCHELL

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, a Notary Public in and for said County and State, personally appeared Kerry Mitchell who acknowledged the execution of the foregoing instrument.

Witness my hand and Notarial Seal this 12th day of January 2024.

Tina M. Switzer

My commission expires: 6/17/2028

County of Residence: Lake

(SEAL)

TINA M. SWITZER
Notary Public - Seal
Lake County - State of Indiana
Commission Number NP0727408
My Commission Expires Jun 17, 2028

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. Richard A. Zunica

This instrument prepared by: Attorney Richard A. Zunica, 162 Washington St., Lowell, IN 46356, File No. 23-23532/ts

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

DEC 13 1991 — Date Issued

[signature] M.D. — Hammond Health Commissioner

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1021

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	Robert G. Mitchell
2. SEX	Male
3a. TIME OF DEATH	3:03 a M
3b. DATE OF DEATH (Month, Day, Yr.)	December 13, 1991
4. SOCIAL SECURITY NUMBER	[illegible]
5a. AGE—Last Birthday (Years)	78
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	March 31, 1913
7. BIRTHPLACE (City and State or Foreign Country)	Vicksburg, IN
8a. WAS DECEDENT A U.S. VETERAN? (Specify)	Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	1945
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number)	St. Margaret's Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH	Hammond
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Widowed
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)	Meat Cutter
12b. KIND OF BUSINESS/INDUSTRY	Kroger
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hammond
13d. STREET AND NUMBER	1155 Summer
13e. ZIP CODE	46320
13f. INSIDE CITY LIMITS	☐ No ☒ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12)	8
College (1-4 or 5+)	5

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	John Mitchell
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Jessie Sisson

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	William Mitchell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1155 Summer - Hammond, IN 46320
20c. Relationship	Son

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Elmwood Cemetery - December 16, 1991
21c. LOCATION—City or Town, State	Hammond, IN
22a. EMBALMER'S NAME	Charles Wells
22b. EMBALMER'S LICENSE NO.	FD01042373
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b. LICENSE NUMBER (of Licensee)	FD01001463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Dalton & Son F.H. FH83002829 6955 Southeastern-Hammond, IN 46324

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

	Cause	Interval
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Bladder Cancer	
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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.

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

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	[signature] Drasga
29c. MEDICAL LICENSE NO.	31484
29d. DATE SIGNED (Month, Day, Year)	December 13, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	R. Drasga, M. D. 8127 Merrillville Road, Merrillville, Indiana 46410

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	[signature] M.D.
32. DATE FILED (Month, Day, Year)	December 13, 1991

CORONER USE ONLY

Field	Entry
33. MANNER OF DEATH	☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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.	

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO 1