



# NOT AN OFFICIAL DOCUMENT

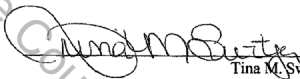
IN WITNESS WHEREOF, Grantor has executed this Affidavit this 12<sup>th</sup> day of January 2024.

  
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.

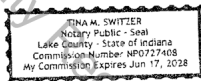
Witness my hand and Notarial Seal this 12<sup>th</sup> day of January 2024.

  
Tina M. Switzer

My commission expires: 6/17/2028

County of Residence: Lake

(SEAL)



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. Zanica

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

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## INDIANA STATE BOARD OF HEALTH

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

DEC 13 1991 *Frank R. D. Remuda, M.D.*  
Date Issued Hammond Health Commissioner

Local No. 1021

### CERTIFICATE OF DEATH

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (Print, Maiden, Last) <b>Robert G. Mitchell</b>		2. SEX <b>Male</b>		3. TIME OF DEATH <b>3:03 A</b>		4. DATE OF DEATH (Month, Day, Year) <b>December 13, 1991</b>	
5. AGE—Last Birthday (Years) <b>78</b>		6. UNDER 1 YEAR Months Days Hours Minutes		8. DATE OF BIRTH (Mo., Day, Yr.) <b>March 31, 1913</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Vicksburg, IN</b>	
9. WAS DECEASED A U.S. CITIZEN? <b>Yes</b>		10. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>		11. PLACE OF DEATH (School, City and State, Hospice) <b>St. Margaret's Hospital Hammond Lake</b>			
12. FACILITY NAME (If not institution, give street and number) <b>St. Margaret's Hospital Hammond</b>		13. CITY, TOWN, OR LOCATION OF DEATH <b>Hammond</b>		14. COUNTY OF DEATH <b>Lake</b>			
15. MARITAL STATUS (Specify) <b>Widowed</b>		16. DECEASED'S USUAL RESIDENCE (City and State or foreign) (Do not use report) <b>Meat Cutter Hammond</b>		17. KIND OF BUSINESS/INDUSTRY <b>Kroger</b>			
18. RESIDENCE—STATE <b>Indiana</b>		19. COUNTY <b>Lake</b>		20. CITY, TOWN, OR LOCATION <b>Hammond</b>		21. STREET AND NUMBER <b>1155 Summer</b>	
22. ZIP CODE <b>46320</b>		23. COUNTRY OF BIRTH <b>USA</b>		24. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>		25. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12) College (1-4 or 2+)</b>	
26. FATHER'S NAME (Print, Maiden, Last) <b>John Mitchell</b>		27. MOTHER'S NAME (Print, Maiden, Married) <b>Jessie Sieson</b>		28. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12) College (1-4 or 2+)</b>			
29. INFORMANT'S NAME (Print, Maiden) <b>William Mitchell</b>		30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>1155 Summer - Hammond, IN 46320</b>		31. Relationship <b>Son</b>			
32. METHOD OF DISPOSITION (Specify) <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Hanging from Stake <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		33. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>December Elmwood Cemetery - 16, 1991 Hammond, IN</b>		34. LOCATION—City or Town, State			
35. EMBALMER'S NAME <b>Charles Wells</b>		36. EMBALMER'S LICENSE NO. <b>FW01042373</b>		37. WAS DEATH REPORTED TO CORONER? <b>Yes</b>			
38. SIGNATURE OF FUNERAL DIRECTOR <i>William C. Hulse</i>		39. LICENSE NUMBER (of Licensee) <b>FW01001463</b>		40. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Walton &amp; Son F.R., FH83002829 6955 Southeastern-Hammond, IN</b>			
41. PART I. Enter the disease, injuries or complications that caused the death (Do not include nonfatal terms, such as stroke or respiratory arrest, shock, or heart failure. List only one cause on each line.) <b>Bladder Cancer</b>							
42. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.							
43. WAS DECEASED PREGNANT OR 30 DAYS POSTPARTUM? (Yes or no) <b>No</b>							
44. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>							
45. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>							
46. CERTIFIER (Check only one) <input checked="" type="checkbox"/> <b>SCRIBING PHYSICIAN</b> 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"/> <b>HEALTH OFFICER</b> 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"/> <b>CORONER</b> 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.							
47. SIGNATURE AND TITLE OF CERTIFIER <i>R. Drasga</i>		48. MEDICAL LICENSE NO. <b>31484</b>		49. DATE SIGNED (Month, Day, Year) <b>December 13, 1991</b>			
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 36) (Print) <b>R. Drasga, M. D. 8127 Merrillville Road, Merrillville, Indiana 46410</b>							
51. HEALTH OFFICER'S SIGNATURE <i>Frank R. D. Remuda, M.D.</i>							
52. DATE FILED (Month, Day, Year) <b>DECEMBER 13, 1991</b>							
53. MANNER OF DEATH							
54. DATE OF INJURY (Month, Day, Year)		55. TIME OF INJURY (Time or not)		56. DESCRIBE HOW INJURY OCCURRED			
57. PLACE OF INJURY (at home, farm, street, factory, office, building, and vicinity)		58. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
59. DATE PRONOUNCED DEAD (Month, Day, Year)							
60. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.							

SDH-06-004

State Form 10110 (R2/3-89)

DEA-CERT/PH-1