

141102 SURVIVORSHIP AFFIDAVIT

James, James & Manning Atty
200 Monticello Dr.
Dyer In 46311

STATE OF INDIANA

COUNTY OF LAKE

{ s. s.

On this December 6 1990 before me personally appeared

KATHLEEN A. BROOMHEAD

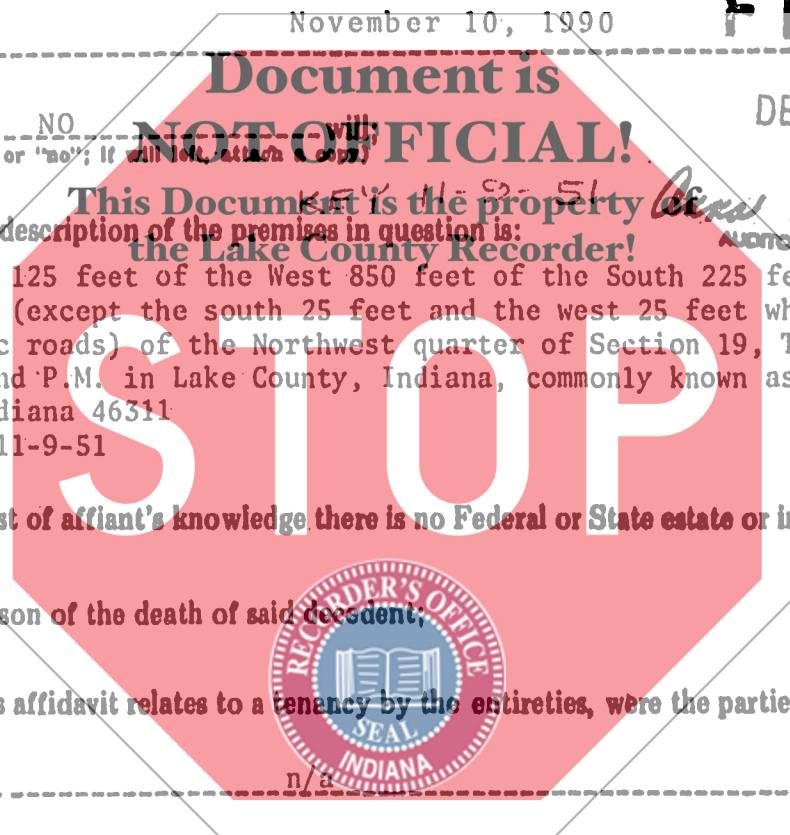
to me personally known, who being duly sworn on oath did say that:

- 1. Affiant resides at the address given below affiant's signature;
- 2. Affiant is surviving joint tenant
(state interest of affiant in the above premises as "owner," "son of owner," etc.)
- 3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Shirley Broomhead and Kathleen A. Broomhead;
- 4. Said Shirley Broomhead
(fill in name of co-tenant who died)

died on November 10, 1990
leaving NO will
(insert "a" or "no"; if will left, attach copy)

FILED
DEC 27 1990

- 5. The legal description of the premises in question is:
The East 125 feet of the West 850 feet of the South 225 feet of the North 455 feet (except the south 25 feet and the west 25 feet which are embraced in public roads) of the Northwest quarter of Section 19, Township 35 N, Range 9 West 2nd P.M. in Lake County, Indiana, commonly known as 14108 Jay Street Dyer, Indiana 46311
Key No. 11-9-51



- 6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent;
- 7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?
n/a

(If answer is "Yes," identify the divorce proceedings:)

- 8. Affiant's relationship to the deceased was

Signature: Kathleen A Broomhead
Kathleen Broomhead
Address: 14108 Jay Street
Dyer, Indiana 46311

Subscribed and sworn to before me by the affiant

this December 6 1990
(insert date)

Raquel Monterrubio
Notary Public
Resident of Lake County
My Commission Expires 9/23/92

00977

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This instrument prepared by Kenneth A. Manning, Dyer, Indiana
Attorney at Law

INDIANA STATE BOARD OF HEALTH

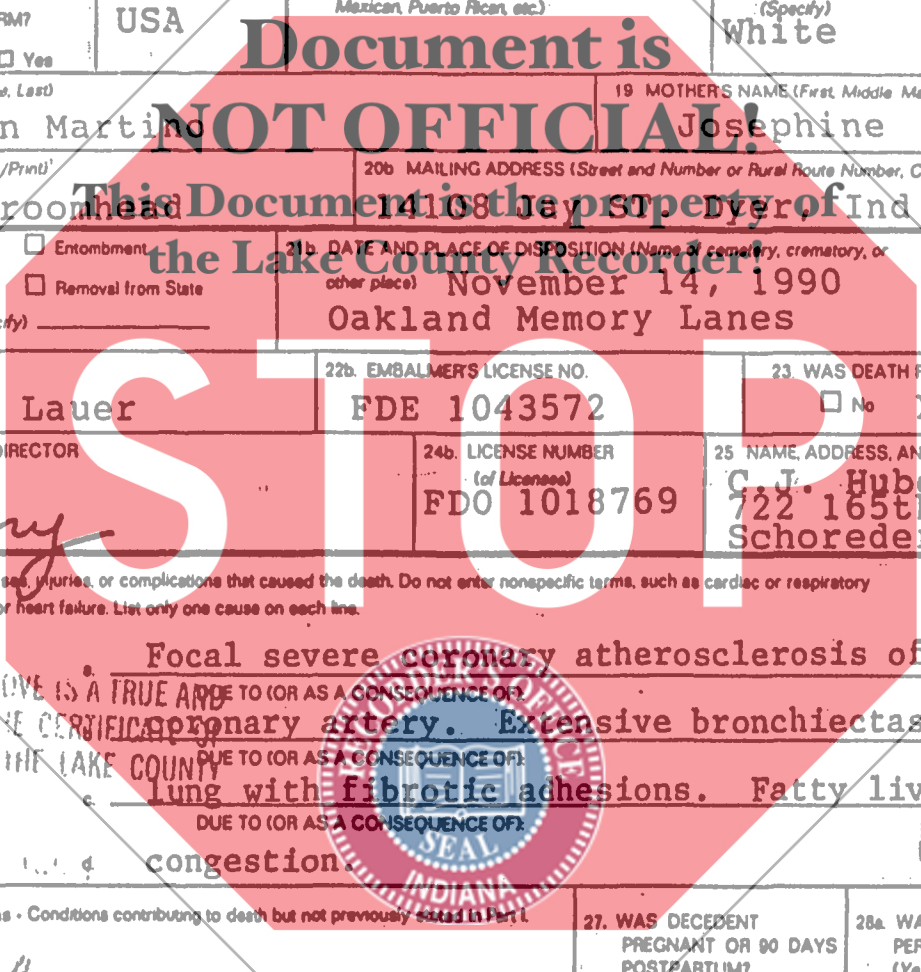
Local No. 2288-90

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) Shirley M. Broomhead		2. SEX Female	3a. TIME OF DEATH M	3b. DATE OF DEATH (Month, Day, Yr) November 10, 1990	
4. SOCIAL SECURITY NUMBER 351-30-2982	5a. AGE—Last Birthday (Years) 52	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo, Day, Yr) March 19, 1938	
7. BIRTHPLACE (City and State or Foreign Country) Hammond, Ind	8a. WAS DECEDENT A U.S. VETERAN? No				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? Never		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____ <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) 14108 Jay St.		9c. CITY, TOWN, OR LOCATION OF DEATH Dyer	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) None	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Own Home	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Dyer	13d. STREET AND NUMBER 14108 Jay St.		
13e. ZIP CODE 46311	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) 11		18. FATHER'S NAME (First, Middle, Last) John Martin			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Unavailable		19. MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable			
20a. INFORMANT'S NAME (Type/Print) Kathleen Broomhead		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14108 Jay St. Dyer, Ind 46311	20c. Relationship Daughter		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) November 14, 1990 Oakland Memory Lanes		21c. LOCATION—City or Town, State Dolton, Illinois	
22a. EMBALMERS NAME Joseph C. Lauer		22b. EMBALMERS LICENSE NO. FDE 1043572	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Rod Luy</i>		24b. LICENSE NUMBER (of Licensee) FDO 1018769	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME C. J. Huber FDH300851 722 165th St. Hammond, Ind. for Schoreder-Lauer F.H. Lansing, MI		
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. Focal severe coronary atherosclerosis of left main coronary artery. Extensive bronchiectasis of right lung with fibrotic adhesions. Fatty liver with congestion.					
26. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) DEC 27 1990	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes		
29a. COUNTY HEALTH OFFICER CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner 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) and manner as stated. <input checked="" 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 <i>Daniel D. Thomas</i>		29c. MEDICAL LICENSE NO. 16120	29d. DATE SIGNED (Month, Day, Year) November 14, 1990		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Daniel D. Thomas</i>				32. DATE FILED (Month, Day, Year) NOV. 14, 1990	
33. MANNER OF DEATH <input checked="" 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) 00978			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) November 10, 1990		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			



Key 11-9-51
 E. 125th St. 200 20
 S. 225th St. 200 20
 S. 197th St. 35 E. 9
 EX S. 25th St. 25th St. 196A

FILED