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Jacob Hb

TICOR TITLE INSURANCE

91022936

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Anne R. Barlow, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Everal E. Barlow died (without leaving a will) (~~leaving a will~~) on February 13 1990 at MUNSTER
2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate: Lot 2 in Block² in Hyde Park Addition, in the City of Hammond as per plat thereof, recorded in Plat Book 12 page 3, in the Office of the Recorder of Lake County, Indiana.

FILED

#34-154-2

MAY 13 1991

Document is NOT OFFICIAL!
the Lake County Recorder!

3. That the marital relationship which existed between them at the time they acquired title to said property remained in effect and unbroken until the date of (his) (her) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not



STATE OF INDIANA/S.S. NO. LAKE COUNTY FILED MAY 15 10 09 AM '91 ROBERT BOBBER RECORDER

Anne R. Barlow
Anne R. Barlow

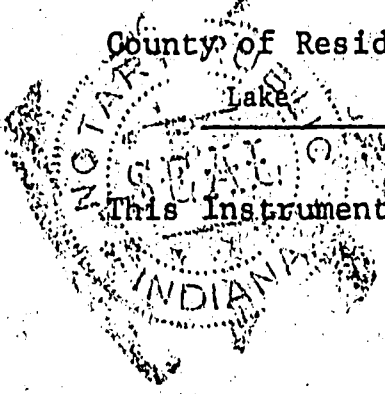
Subscribed and sworn to before me, a Notary Public, this 26th day of April, 1991

Linda S. Wood
Linda S. Wood Notary Public

My Commission expires: 10-17-94

County of Residence: Lake

This Instrument prepared by Anne R. Barlow



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INDIANA STATE BOARD OF HEALTH

158947

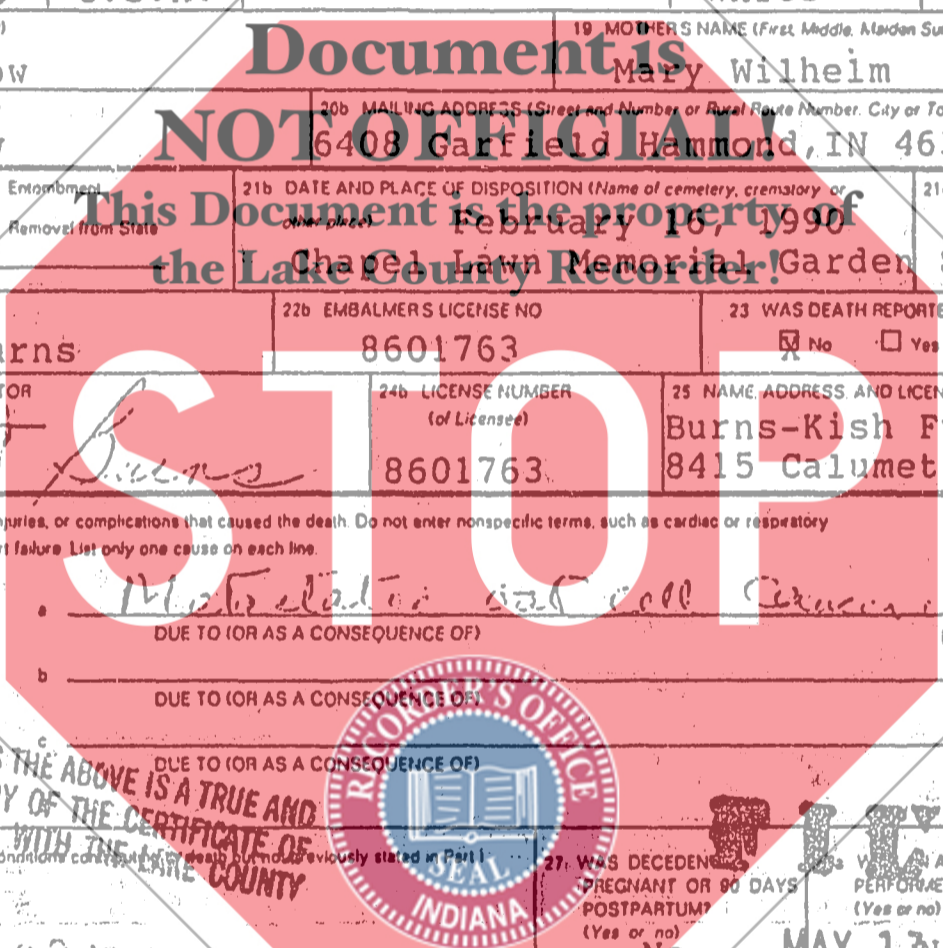
Local No. 426-90

CERTIFICATE OF DEATH

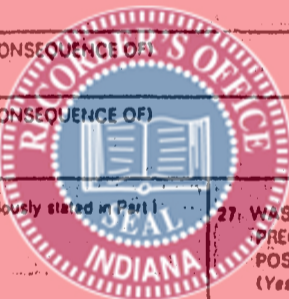
State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Everald Barlow		2 SEX Male	3a TIME OF DEATH 9:50A	3b DATE OF DEATH (Month Day Year) February 13, 1990
7 SOCIAL SECURITY NUMBER 491016-5819	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Oct. 3, 1919
8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) Community Hospital		9c CITY, TOWN OR LOCATION OF DEATH Munster	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Anne Bukoski	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Foreman	12b KIND OF BUSINESS, INDUSTRY Inland Steel	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 6408 Garfield Ave.	
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) David Barlow		
19 MOTHER'S NAME (First Middle Maiden Surname) Mary Wilhelm		20a INFORMANT'S NAME (Type, Print) Anne Barlow		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6408 Garfield Hammond, IN 46324		20c Relationship Wife		
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) February 16, 1990 Chapel Lawn Memorial Garden Schererville, IN		21c LOCATION—City or Town, State
22a EMBALMER'S NAME Brian T. Burns		22b EMBALMER'S LICENSE NO. 8601763	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Brian T. Burns</i>		24b LICENSE NUMBER (of Licensee) 8601763	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Myocardial infarction with all causes of the preceding DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ 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 contributing to death but not previously stated in Part I MAD 02 1990				
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No		28b WERE AUTOPSY FINDINGS PERFORMED? (Yes or no) MAY 13 1991
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 <i>Charles Johnson</i>		29b 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 <i>Charles Johnson</i>		
29c SIGNATURE AND TITLE OF CERTIFIER <i>Charles Johnson</i> LAKE COUNTY HEALTH COMMISSIONER		29d MEDICAL LICENSE NO. 27970	29e DATE SIGNED (Month, Day, Year) March 2, 1990	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Salman D. Gallani, M.D. 9116 Columbia Ave. Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Charles Johnson</i>				32 DATE FILED (Month, Day, Year) March 2, 1990
33 MANNER OF DEATH <input 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, school, 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		



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.



FILED

DECEASED
PARENTS
INFORMANT
DISPOSITION
CAUSE OF DEATH
CERTIFIER
HEALTH OFFICER
CORONER USE ONLY

34-154-a
Wpde Pk Add. Rta Bld

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