

SURVIVORSHIP AFFIDAVIT

STATE OF Indiana } S. S. 501-01-7947
COUNTY OF Lake }
81024624

On this May 9 1991 before me personally appeared _____
(insert date)

Helen W. M. Jones

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 owner _____
(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 Richard W. Jones and Helen W. M. Jones;
- 4. Said Richard W. Jones _____
(fill in name of co-tenant who died)

died on Feb 7 1989 _____
leaving no will;
(insert "a" or "will" with left attach copy)

5. The legal description of the premises in question is:
Lot 2, Block 2, Hansen Park Addition, to the City of Hammond, Indiana, as shown in Plat Book 20, page 44, in Lake County, Indiana
Key # 34-37-2

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?
no

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

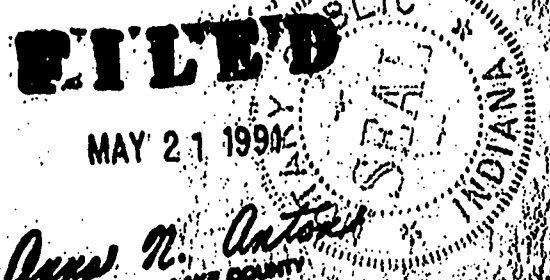
8. Affiant's relationship to the deceased was Spouse

Signature: Helen W. M. Jones
Helen W. M. Jones
Address: 7070 Monroe Av

Subscribed and sworn to before me by the affiant:
this 9th day of May
(insert date)

Doris D. Slayden
Notary Public
Doris D. Slayden
My Commission Expires 2-28-95
Resident of Lake County

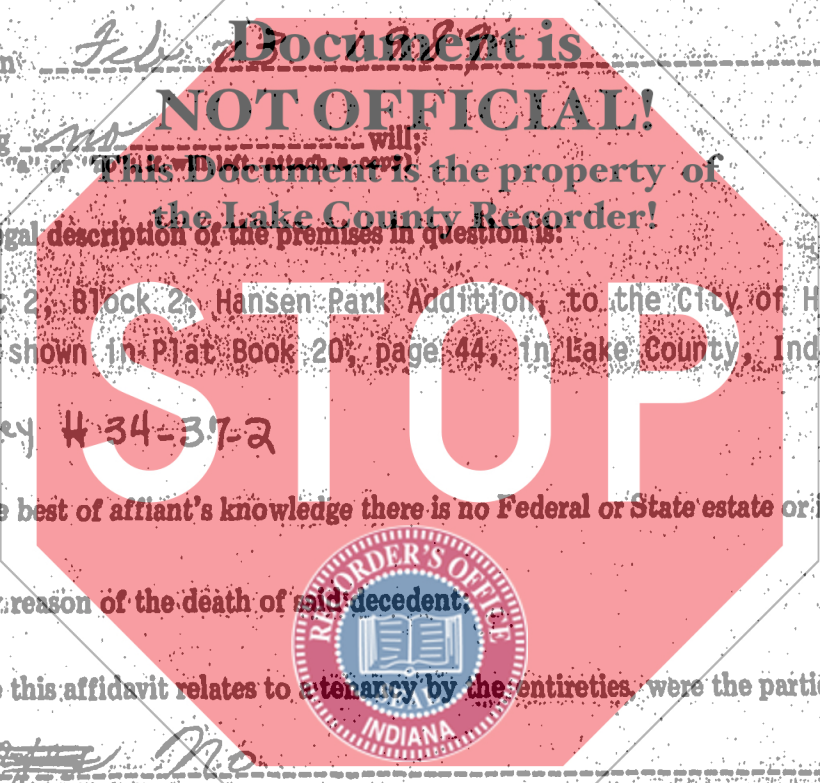
This instrument prepared by Helen W. M. Jones



MAY 21 1991

00919

CHICAGO TITLE INSURANCE COMPANY INDIANA DIVISION



STATE OF INDIANA'S S. NO. LAKE COUNTY FILED MAY 22 11 25 PM '91 ROBERT W. P. REYNOLDS RECORDER

800 67

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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

FEB 27 1989
Date Issued Hammond Health Comm.

TYPE/PRINT
IN
PERMANENT
BLACK-INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING
PHYSICIAN ONLY

ITEMS 24-26 MUST
BE COMPLETED BY
PERSON WHO
PRONOUNCES DEATH

SEE INSTRUCTION

CAUSE OF
DEATH

SEE INSTRUCTION

CERTIFIER

HEALTH
OFFICER

CORONER OR
MEDICAL
EXAMINER USE
ONLY

146

Local No.

1. DECEASED—NAME FIRST MIDDLE LAST
Richard W. Jones

2. SEX Male

3. DATE OF DEATH (Mo. Day, Yr.) February 23

4. SOCIAL SECURITY NUMBER 314-14-4307

5a. AGE—Last Birthday (Years) 66

5b. UNDER 1 YEAR Months Days

5c. UNDER 1 DAY Hours Minutes

6. DATE OF BIRTH (Month, Day, Year) December 31, 1922

7. BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana

8. YEAR LAST SERVED IN U.S. ARMED FORCES 1945

9. PLACE OF DEATH (Check only one. See instructions)
HOSPITAL Inpatient ER/Outpatient DOA OTHER Nursing Home Residence Other (Specify)

10. FACILITY NAME (If not mentioned, give street and number) St. Margaret Hospital

11. CITY, TOWN, OR LOCATION OF DEATH Hammond

12. COUNTY OF DEATH Lake

13. MARITAL STATUS—Married Never Married, Widowed, Married

14. SURVIVING SPOUSE (If wife, give maiden name) Helen Hansen

15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Gas Engineer

16. KIND OF BUSINESS/INDUSTRY NIPSCO

17. RESIDENCE—STATE Indiana

18. COUNTY Lake

19. CITY, TOWN, OR LOCATION Hammond

20. STREET AND NUMBER 7020 Monroe

21. INSIDE CITY LIMITS? (Yes or no) Yes

22. FARM No

23. ZIP CODE 46324

24. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes, specify Cuban, Mexican, Puerto Rican, etc.) No

25. RACE—American Indian, Black, White, etc. (Specify) White

26. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13 or more) 3

27. FATHER'S NAME (First Middle Last) Thomas Jones

28. MOTHER'S NAME (First Middle Maiden Surname) Hazel Munson

29. INFORMANT'S NAME (Type/Print) Helen Jones

30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7020 Monroe Hammond, Indiana 46324

31. Relationship wife

32. METHOD OF DISPOSITION
 Burial Cremation Removal from State Other (Specify)

33. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Elmwood Cemetery Hammond, Indiana

34. LOCATION—City or Town, State Hammond, Indiana

35. SIGNATURE OF FUNERAL DIRECTOR *Rodney J. ...*

36. LICENSE NUMBER FDE 1018769

37. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME C.J. Huber Funeral Home 722 165th Street Hammond, Indiana FDH3002851

38. LICENSE NUMBER 29300

39. DATE SIGNED (Month, Day, Year) Feb. 23, 1989

40. TIME OF DEATH 11:12 A.M.

41. DATE PRONOUNCED DEAD (Month, Day, Year) February 23, 1989

42. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No

43. PART I: Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.
 IMMEDIATE CAUSE (Final disease or condition resulting in death)
 Sequence of conditions, if any, leading to immediate cause: Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.
 • *Cardiac failure, arrest*
 DUE TO (OR AS A CONSEQUENCE OF)
 • *Acute myocardial infarction*
 DUE TO (OR AS A CONSEQUENCE OF)
 •
 DUE TO (OR AS A CONSEQUENCE OF)

44. PART II: Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.

45. WAS AN AUTOPSY No

46. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO SIGNATURE OF CAUSE OF DEATH? N/A

47. CERTIFIER (Check only one)
 CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed this certificate. To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
 PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death. To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
 MEDICAL EXAMINER CORONER 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.)

48. SIGNATURE AND TITLE OF CERTIFIER *David N. Anton*
 49. LICENSE NUMBER IN 20248
 50. DATE SIGNED (Month, Day, Year) February 24, 1989

51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 31) (Type/Print) W.V. HETTMANN, MD 7905 CANNON AVE MONSTER, IN 46321

52. HEALTH OFFICER'S SIGNATURE *Franklin D. Remuda, M.D.*

53. MANNER OF DEATH
 Natural Pending Investigation
 Accident Could not be Determined
 Suicide Homicide

54. DATE OF INJURY (Month, Day, Year)

55. TIME OF INJURY

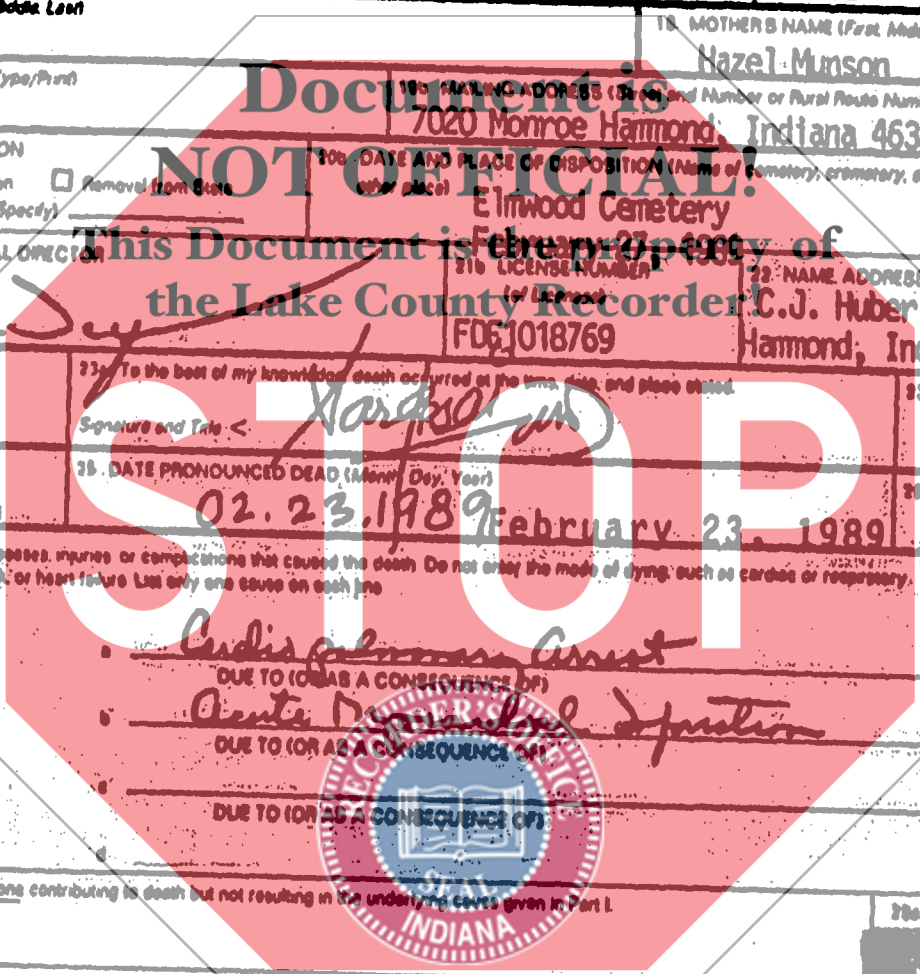
56. INJURY AT WORK? (Yes or no)

57. DESCRIBE HOW INJURY OCCURRED

58. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)

59. LOCATION (Street and Number or Rural Route Number, State) 00320

60. DATE FILED (Month, Day, Year) FEB 27 1989



34-372
Hansen, D. ...