

452384



Chicago Title Insurance Company

452384 plg 5065
Independence One Mtg
5241 Fountain Drive
Suite C
Crown Point, IN 46307

SURVIVORSHIP AFFIDAVIT

STATE OF **91026631**

S. S.

COUNTY OF

On this May 15, 1991 before me personally appeared GERALD E. MUSSER
(insert date)

MUSSER

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 ONE OF THE RECORD OWNERS OF TITLE
(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
GERALD E. MUSSER and MARGARET M. MUSSER

4. Said MARGARET M. MUSSER
(fill in name of co-tenant who died)

died on March 2, 1989

leaving no will; (SEE ATTACHED COPY OF DEATH CERTIFICATE)
(insert "a" or "b" if will left attached copy)

5. The legal description of the premises in question is: Lot 4, Block 1, J.J. Owen's Addition to Hammond, as shown in plat book 20, page 34, in Lake County, Indiana.
COMMON STREET ADDRESS: 7548 Monroe, Hammond, Indiana
KEY #35-200-4 TAX UNIT NO. 26

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance 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?
THE PARTIES WERE NEVER DIVORCED

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

8. Affiant's relationship to the deceased was SURVIVING SPOUSE

Signature: Gerald E. Musser
GERALD E. MUSSER

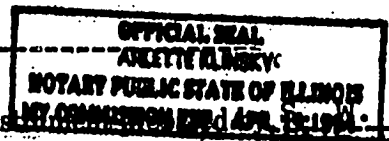
Address: 7548 Monroe, Hammond, IN

Subscribed and sworn to before me by the affiant

this May 15, 1991
(insert date)

Angie Klusky
Notary Public

My Commission Expires



This instrument was recorded on 0115 PAGOREK, ATTORNEY AT LAW
717 Burnham Avenue, Calumet
City, IL 60409

FILED

MAY 29 1991

Anna M. Untch
AUDITOR LAKE COUNTY

CHICAGO TITLE INSURANCE COMPANY
INDIANA DIVISION

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED FOR RECORD
MAY 31 1 31 PM '91
ROBERT (BOB) FRITLAND
RECORDER

80 CT

MEDICAL CERTIFICATE OF DEATH
MARION COUNTY HEALTH DEPARTMENT
 222 EAST OHIO STREET
 INDIANAPOLIS INDIANA 46204

Local No.

State No.

TYPE/PRINT
 IN
 PERMANENT
 BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING
 PHYSICIAN ONLY

ITEMS 23 TO 26 MUST
 BE COMPLETED BY
 PERSON WHO
 PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF
 DEATH

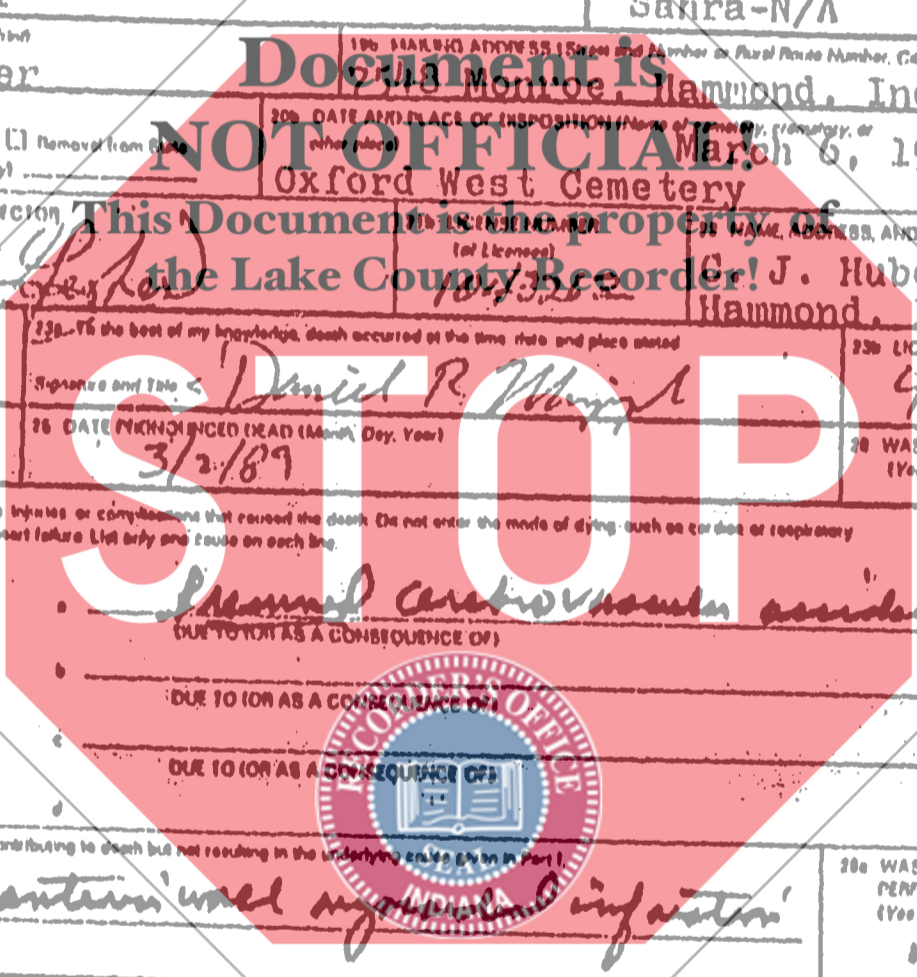
SEE INSTRUCTIONS

CERTIFIER

HEALTH
 OFFICER

CORNER OR
 MEDICAL
 EXAMINER USE
 ONLY

1 DECEASED—NAME MARGARET A. MUSSER		2 SEX F	3 DATE OF DEATH (Month, Day, Year) 3-2-89
4 SOCIAL SECURITY NUMBER 307-01-2191		5a UNDER 1 YEAR Months: 79	5b UNDER 1 DAY Hours: _____ Minutes: _____
6 YEAR LAST SERVED IN US ARMED FORCES No		8 DATE OF BIRTH (Month, Day, Year) JUNE 25, 1909	
7 BIRTHPLACE (City and State or Foreign Country) Oxford, Indiana		9a PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
10 FACILITY NAME (If not institution, give street and number) St. Vincent Hospital		11 CITY, TOWN OR LOCATION OF DEATH Indpls, Ind	12 COUNTY OF DEATH Marion
13a MARITAL STATUS (Married, Never Married, Widowed, Divorced) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Gerald Musser	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker	12b KIND OF BUSINESS/INDUSTRY Home
13a RESIDENCE—STATE Indiana	13b CITY, TOWN OR LOCATION Lake Hammond, Ind	13c STREET AND NUMBER 7548 Monroe	
13d RIBBON CITY (LMI 11) (Yes or no) Yes	13e FARM No	13f ZIP CODE 46324	14 WAS DECEASED OF HISPANIC ORIGIN? (Specify No or Yes. If yes specify Cuban, Mexican, Puerto Rican, etc.) No
15 FATHER'S NAME (Full Name Last) Jacob Keller		16 MOTHER'S NAME (Full Middle Maiden Surname) Sakira-N/A	
17 INFORMANT'S NAME (If patient) Gerald Musser		18 MARITAL ADDRESS (Street and Number, City or Town, State, Zip Code) 7548 Monroe, Hammond, Indiana 46324	19a Relationship Husband
20a 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)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 6, 1989 Oxford West Cemetery Oxford, Indiana	
21a BIRTHPLACE OF FUNERAL DIRECTOR Greenville, S.C.		21b NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Gr. J. Huber Funeral Home-3000 6th Hammond, Indiana 46324	
22a TO the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: Daniel R. Murray		23a LICENSE NUMBER 43699	23b DATE SIGNED (Month, Day, Year) 3/1/89
24 TIME OF DEATH 6:45 AM		25 DATE KNOWN (Month, Day, Year) 3/2/89	
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No			
27 PART I: Enter the disease, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Strained cerebral vessels accident (DUE TO OR AS A CONSEQUENCE OF)			
28 PART II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. recent untreated myocardial infarction			
29a CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and certified item 23) <input checked="" type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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.)		29b LICENSE NUMBER 29804	29c DATE SIGNED (Month, Day, Year) 3-2-89
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 21) (Type/print) V.M. BOURNIGALE 8402 HARROVAT RD. SUITE 400 INDPLS, 46260			
31 HEALTH OFFICER'S SIGNATURE Frank Thomas			32 DATE FILED (Month, Day, Year) MAR 14 1989
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY
34c PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34d INJURY AT WORK? (Yes or no)	34e DESCRIBE HOW INJURY OCCURRED
35 LOCATION (Street and Number or Rural Route Number, City or town, State)			



REVERSE SIDE
 INDIANA DIVISION
 NOT VALID UNLESS MACHINE JUMBELED AND SIGNED