(1) 161377 SARDA

TICOR #8

TICOR TITLE INSURANCE

91042005 AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AUG 19 10 37 AM '91
ROBERT VOSS FREELAND
RECORDER
STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD

William A. Stockwell, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Cynthia G. Stockwell died (without leaving a will) (~~leaving a will~~) on May 6 19 90 at St. Margaret Hospital, Hammond, Indiana

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate: 1823 Lincolnwood Road; Schererville, Indiana

#13-147-2

Lot 2 in Bohling's Shawnee Trails Addition Unit No. 1, in the Town of Schererville, as per plat thereof, recorded in Plat Book 36 page 61, in the Office of the Recorder of Lake County, Indiana.

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of ~~xxxx~~ (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.

William A. Stockwell

Subscribed and sworn to before me, a Notary Public, this 5th day of August, 1991.

Richard Wirtz
Notary Public
RICHARD WIRTZ

My Commission expires:
6/26/92

County of Residence:
LAKE

FILED

Instrument prepared by William A. Stockwell

AUG 15 1991

Anna N. Antone
AUDITOR LAKE COUNTY

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TIGR

Local No. 399

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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

MAY 8 1990 Franklin D. Jremuda M.D.
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Cynthia G. Stockwell
2. SEX: Female
3a. TIME OF DEATH: 7:17 PM
3b. DATE OF DEATH (Month, Day, Yr): May 6, 1990
4. SOCIAL SECURITY NUMBER: 316-54-7818
5a. AGE—Last Birthday (Years): 42
5b. UNDER 1 YEAR — Months / Days:
5c. UNDER 1 DAY — Hours / Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): March 30, 1948
7. BIRTHPLACE (City and State or Foreign Country): Steubenville, Ohio
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? —
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): William Stockwell
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: At Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Schererville
13d. STREET AND NUMBER: 1823 Lincolnwood Road
13e. ZIP CODE: 46375
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Leon Williams
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Jones

INFORMANT

20a. INFORMANT'S NAME (Type/Print): William Stockwell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1823 Lincolnwood Rd. Schererville, IN 46375
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 9, 1990 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Dennis Lapine
22b. EMBALMER'S LICENSE NO.: FD08700141
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Ronald J. Mesarch
24b. LICENSE NUMBER (of Licensee): FD01005912
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410

CAUSE OF DEATH

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	PULMONARY EMBOLISM	12 HRS
DUE TO (OR AS A CONSEQUENCE OF) b.	METASTATIC BREAST CARCINOMA	2 YRS
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) —

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: Mark Stk — MD
29c. MEDICAL LICENSE NO.: 36785
29d. DATE SIGNED (Month, Day, Year): May 8, 1990

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M. Kevin, M.D. 7905 Calumet Avenue, Munster, Indiana 46321
31. HEALTH OFFICER'S SIGNATURE: Franklin D. Jremuda M.D.
32. DATE FILED (Month, Day, Year): May 8, 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) (Operator, driver, passenger, pedestrian, etc.)

FILED
AUG 15 1991
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AUDITOR LAKE COUNTY