

91055410



# TICOR TITLE INSURANCE

## AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

ROBERT R. KREMLAND  
RECORDER

NOV 1 9 13 AM '91

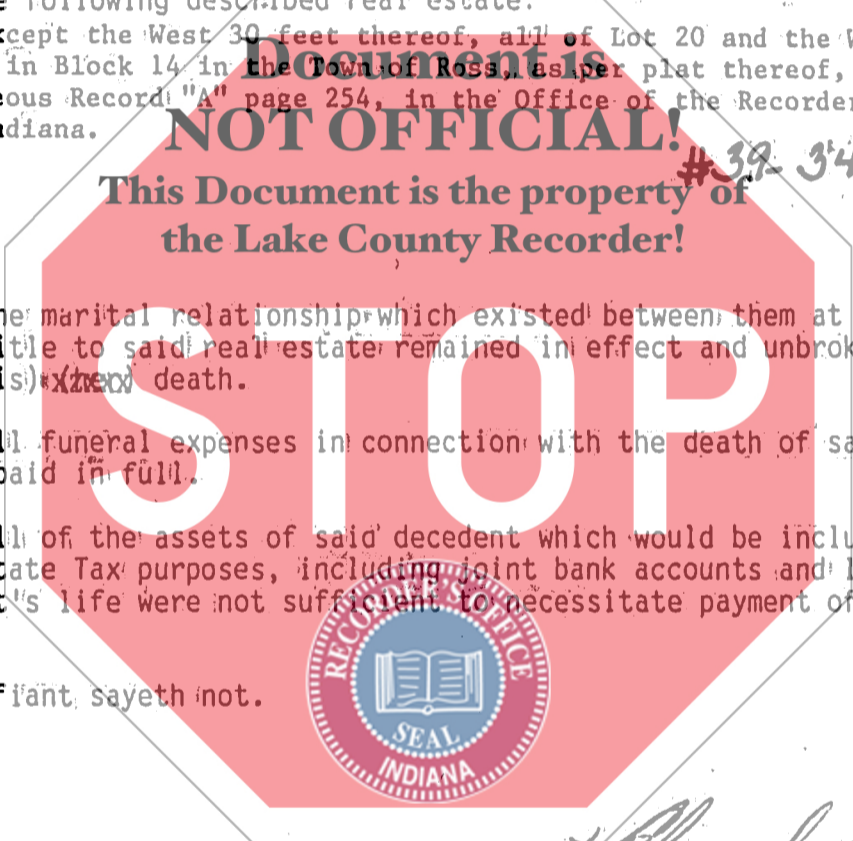
STATE OF INDIANA  
LAKE COUNTY  
FILED RECORD

aka Edward A. Sullivan  
Edward Sullivan / personal representative of Eula Lee, being first duly  
sworn upon oath, deposes and says: Sullivan

1. That Roy E. Sullivan died on  
November 14, 1991 at Merrillville, Indiana.

2. That Roy E. Sullivan and Eula Lee Sullivan  
were duly and legally married at the time they acquired title as husband and  
wife to the following described real estate:

Lot 19, except the West 30 feet thereof, all of Lot 20 and the West 15 feet  
of Lot 21 in Block 14 in the Town of Ross, as per plat thereof, recorded in  
Miscellaneous Record "A" page 254, in the Office of the Recorder of Lake  
County, Indiana.



#39-344-19

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 (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.

*Edward A. Sullivan*  
Edward Sullivan, as personal representative of Eula

Subscribed and sworn to before me, a Notary Public, this 18th day of Lee  
October, 1991. \*aka Edward A. Sullivan Sullivan

**FILED**

OCT 30 1991

*Paula Barrick*  
Paula Barrick Notary Public

My Commission expires:

10-3-92

*Anna N. Anton*  
AUDITOR LAKE COUNTY

County of Residence:

Lake

This Instrument prepared by Edward Sullivan, personal representative of Eula Lee Sullivan

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800  
te

3140 W. 48th Pl. Gary, Ind. 46408

076987

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
TIN  
PERMANENT  
BLACK/INK

DECEDENT

INFORMANT

DISPOSITION

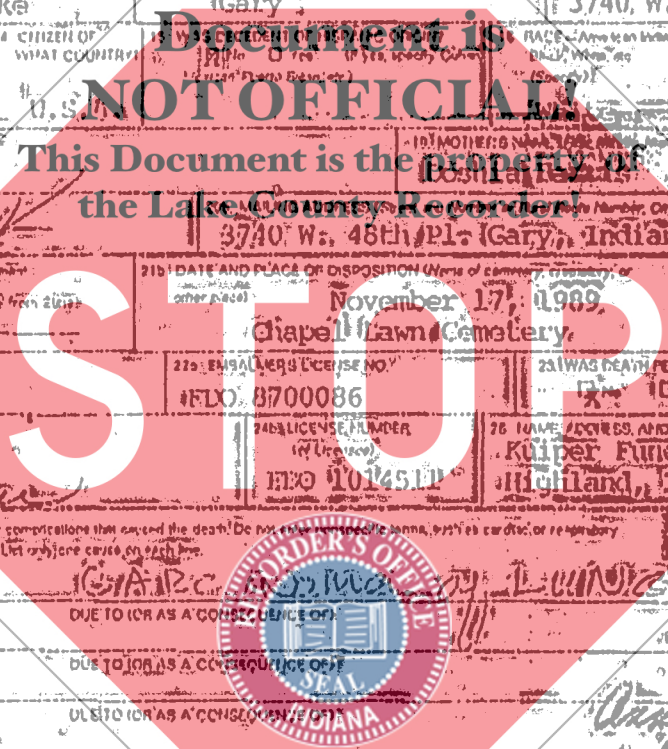
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

OPERATOR  
SE ONLY

1. DECEASED NAME (Type in full) <b>Roy E. Sullivan</b>		2. SEX <b>Male</b>	3. TIME OF DEATH <b>3:25 P.</b>	3b. DATE OF DEATH (Month, Day, Year) <b>November 17, 1989</b>
4. SOCIAL SECURITY NUMBER <b>416-07-5217</b>		5a. AGE - Last Birthday (Year) <b>81</b>	5b. UNDER 1 YEAR <b>Days</b>	5c. UNDER 1 DAY <b>Hours Minutes</b>
6. DATE OF BIRTH (MM, Day, Yr) <b>JUL 22, 1908</b>		7. BIRTH PLACE (City and State or Foreign Country) <b>Missville, Alabama</b>		
8. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		9. YEAR/ST. SERVED IN U.S. ARMED FORCES? <b>WW-II</b>		10. PLACE OF DEATH (City and State) <b>Methodist Hospital Southlake Campus, Merrillville, Lake</b>
11. FACILITY NAME (If not in table, give street and number) <b>Methodist Hospital Southlake Campus</b>		12. CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>		13. COUNTY OF DEATH <b>Lake</b>
14. MARITAL STATUS (If separated, give date) <b>Married</b>		15. SURVIVING SPOUSE (If wife, give maiden name) <b>Eula Lee Parker</b>		16. DECEASED'S USUAL OCCUPATION (One kind of work done during most of working life. Do not use retired) <b>Foreman</b>
17. KIND OF BUSINESS/INDUSTRY <b>Steel Co.</b>		18. RESIDENCE - STATE <b>Indiana</b>		
19. COUNTY <b>Lake</b>		20. CITY, TOWN, OR LOCATION <b>Gary</b>		21. ALLEGET AND NUMBER <b>3740 W. 48th Pl.</b>
22. ZIP CODE <b>46408</b>		23. OFFICE CITY, LIMITS <b>Yes</b>		24. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
25. RACE - American Indian, Black, White, etc. <b>White</b>		26. PLACE, YEAR, EDUCATION <b>High School</b>		
27. FATHER'S NAME (Type in full) <b>Walter Sullivan</b>		28. MOTHER'S NAME (Type in full) <b>...</b>		
29. INFORMANT'S NAME (Type in full) <b>Eula Lee Sullivan</b>		30. ADDRESS (Street, Box, P.O., Fish Number, City or Town, State, Zip Code) <b>3740 W. 48th Pl. Gary, Indiana</b>		
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>November 17, 1989 Chapel Lawn Cemetery</b>		33. LOCATION - City, Town, State <b>Schererville, Indiana</b>
34. EMBALLER'S NAME <b>Raymond White</b>		35. EMBALLER'S LICENSE NO. <b>INDO. 8700086</b>		36. WAS DEATH REFERRED TO CORONER? <b>Yes</b>
37. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		38. LICENSE NUMBER (If Licensed) <b>INDO 1014511</b>		39. NAME, ADDRESS, AND PHONE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDN 300-7500</b>
40. PART I - Enter the disease or diseases that caused the death. Do not enter remote causes, such as cardiac or respiratory. <b>ICHAIC</b>		41. IMMEDIATE CAUSE (Final cause of death) <b>DUE TO ICR AS A CONSEQUENCE OF</b>		
42. CAUSE OF DEATH (Including in death) <b>DUE TO ICR AS A CONSEQUENCE OF</b>		43. CAUSE OF DEATH (Including in death) <b>DUE TO ICR AS A CONSEQUENCE OF</b>		
44. PART II - Other significant conditions - Conditions contributing to death, not previously stated in Part I.		45. YEAR DECEDENT PREGNANT OR 90 DAYS POSTPARTUM <b>No</b>		
46. WAS ALL AUTOPSY PERFORMED? <b>No</b>		47. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE? <b>No</b>		
48. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (On the basis of knowledge and/or direct observation at the time, date, and place, and due to the cause(s) 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) as stated) <input 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)		49. THIS CERTIFICATE IS A TRUE AND CORRECT COPY OF THE ORIGINAL <b>Yes</b>		
50. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		51. DATE SIGNED (Month, Day, Year) <b>11/23/89</b>		
52. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		53. DATE FILED (Month, Day, Year) <b>11/23/89</b>		
54. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		55. DATE OF INJURY (Month, Day, Year) <b>11/16/89</b>		56. TIME OF INJURY <b>...</b>
57. NATURE OF INJURY (Type or describe) <b>...</b>		58. DISCREPANCY IN INJURY OCCURRED? <b>No</b>		
59. PLACE OF INJURY - At home, in a place, factory, office, street, etc. (Specify) <b>...</b>		60. LOCATION (Street and Number or Rural Route Number) <b>...</b>		
61. DATE PRONOUNCED DEAD (Month, Day, Year) <b>11/16/89</b>		62. MOTOR VEHICLE ACCIDENT? (Yes or No) (If yes, specify driver, passenger, pedestrian, etc.) <b>No</b>		



3740 W. 48th Pl. Gary, Ind. 46408

APR 11 1990

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