


Cain died the owner of said real estate on the 30th day of March, 1991.

That the decedents, Alonzo J. Cain and Bethellyn Cain, husband and wife, held title to said real estate as husband and wife until the death of Alonzo J. Cain on the 27th day of June, 1975, at which time the said Bethellyn Cain acquired title to the real estate as the surviving joint tenant.


That the gross value of the estate of the decedent, Alonzo J. Cain, as determined for the purposes of U. S. Estate Tax was less than the value required for the filing of a U. S. Estate Tax Return, as a consequence of which the decedent's estate was not subject to U. S. Estate Tax. Further that the gross value of the estate of the decedent, Bethellyn Cain, as determined for the purpose of U. S. Estate Tax was less than the value required for the filing of a U. S. Estate Tax Return, as a consequence of which the decedent's estate was not subject to U. S. Estate Tax.

That the inheritance tax payable by reason of the death of Bethellyn Cain, deceased, will be determined and paid by the affiant in the immediate future.

IN WITNESS WHEREOF the affiant has hereunto subscribed her name and seal this 21st day of January, 1992.


Glyndona A. Cain-Greven
Glyndona A. Cain-Greven

Subscribed and sworn to before the undersigned Notary
in and for said County and State the date and year above written.



Harry R. Kneifel, Sr.
Notary Public

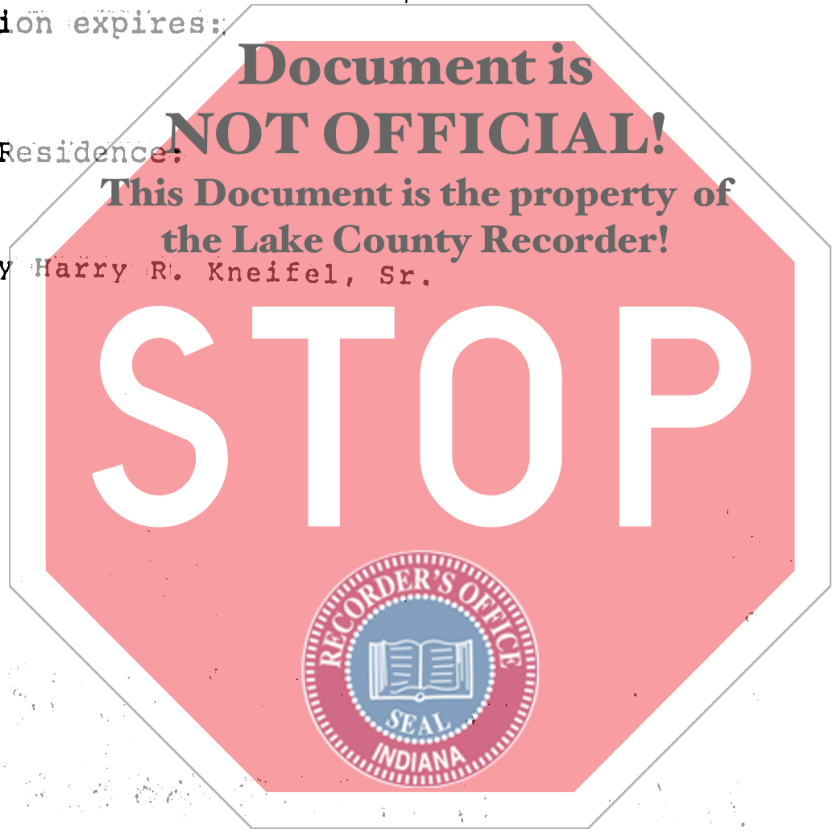
My Commission expires:

9-14-92

County of Residence:

Lake

Prepared by Harry R. Kneifel, Sr.



CITY OF EAST CHICAGO, INDIANA
DEPARTMENT OF HEALTH
CITY HALL

Local Record of Death

165061

THIS IS TO CERTIFY,

That our records show

Document is *Mary J. Quinn*
NOT OFFICIAL

died

June 27 1975 This Document is the property of *St. Catherine Hospital & Clinic, Indiana*
MONTH DAY YEAR PLACE STREET, HOSPITAL

Age at Death *55* Sex *Male* Married Widowed
Years Months Days

Birth Date *9-9-1919* Color *White* Single Divorced
Month Day Year

Primary cause of death given was *Adeno Carcinoma of Right Lung*

Signed by *Forrest R. Barfield, M.D., Hammond, Ind.*
Physician Address

Place of burial or removal *Mater Colosoa, Owensboro, Kentucky*
Name of Cemetery

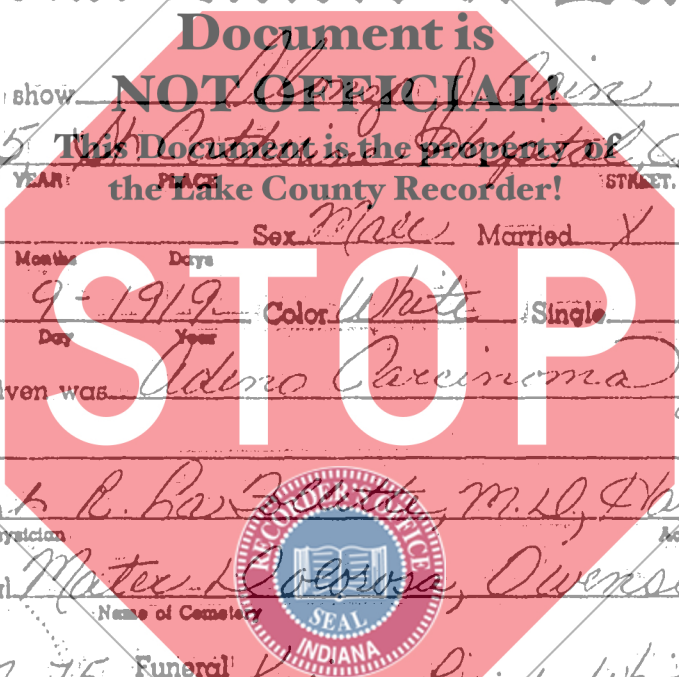
Date of burial *7-2-75* Funeral Director *Ralph Whiting, Indiana*
Address

Signed *E.A. Campagna, M.D.* Sec'y

at East Chicago, Indiana *4-2-79*
Date

Filed *7-9-75* 01841

Recorded locally in Book No. *1975 Vol.* Page No. *81* Registered No. *401*



91-110-H-13-D
 Harry Kneifel
 INDIANA STATE BOARD OF HEALTH

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

APR 04 1991
 Date Issued
 Hammond Health Commissioner

Local No. 252

CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Bethel Lynn Cain		2 SEX Female	3a TIME OF DEATH 11:55 a.	3b DATE OF DEATH (Month Day Yr) March 30, 1991
4 SOCIAL SECURITY NUMBER 305-20-1778	5a AGE—Last Birthday (Years) 67	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) May 30, 1923
7 BIRTHPLACE (City and State or Foreign Country) Fordsville, Kentucky	8a WAS DECEDENT A US VETERAN? No			
8b YEAR LAST SERVED IN US ARMED FORCES? -		8c 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		
9a FACILITY NAME (If not institution, give street and number) St. Margaret Hospital		9b CITY, TOWN OR LOCATION OF DEATH Hammond		9c COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife, give maiden name) -	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Inspector		12b KIND OF BUSINESS/INDUSTRY Simmons Mattress Co.
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Whiting	13d STREET AND NUMBER 1812 1/2 Oliver Avenue	
13e ZIP CODE 46394	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) 12		18 FATHER'S NAME (First Middle Last) Smith Miles		
19 MOTHER'S NAME (First Middle Maiden Surname) Gola Brown		20a INFORMANT'S NAME (Type/Print) Wayne B. Cain		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Heritage Dr. Dyer, IND 46311		20c Relationship Son		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Specify if other place) APRIL 1, 1991 Miles Cemetery		21c LOCATION—City or Town, State Ohio County, Kentucky
22a EMBALMER'S NAME Woodrow W. Donovan		22b EMBALMER'S LICENSE NO. FD01053135	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>John S. Jife</i>		24b LICENSE NUMBER (of Licensee) FD01020366	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FIFE FUNERAL HOME, INC. - FH83001512 4201 Indpls. Blvd. East Chicago, IND	
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. Cardiac Arrest Cancer				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a DUE TO (OR AS A CONSEQUENCE OF) b DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) d				
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 RESULTS AVAILABLE PRIOR TO COMPLETION OF DEATH? (Yes or no)	
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 <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				
29b SIGNATURE AND TITLE OF CERTIFIER <i>S. Makam</i>			29c MEDICAL LICENSE NO. 31764	29d DATE SIGNED (Month, Day, Year) April 3, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) S. Makam, M.D. 9112 Columbia Avenue, Munster, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin R. Remuda, M.D.</i>				32 DATE FILED (Month, Day, Year) APR 04 1991
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <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 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) If yes, specify driver, passenger, pedestrian, etc.		

1925 9 1

PARENTS INFORMANT

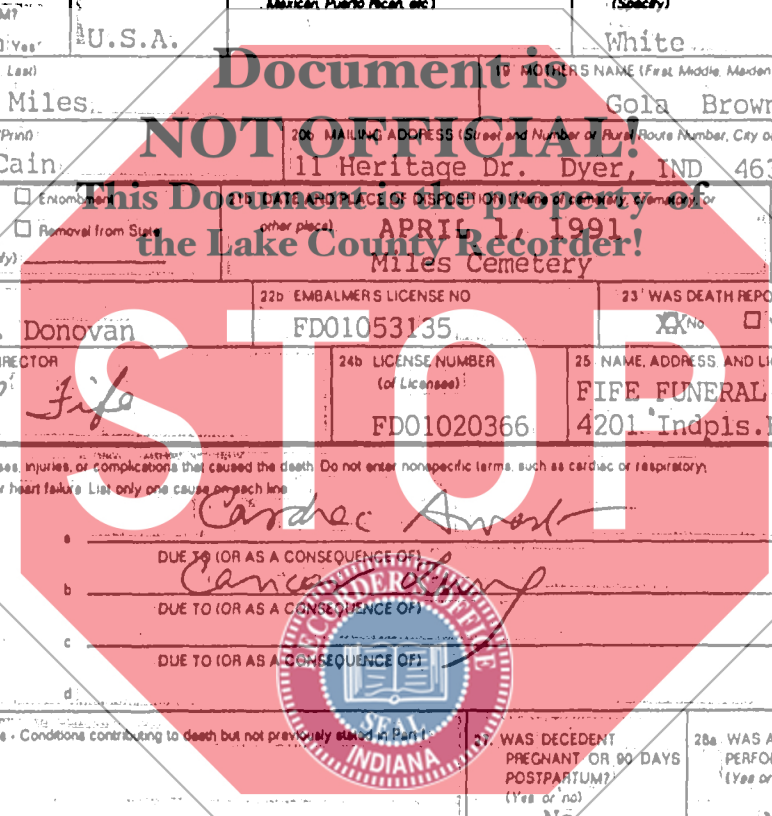
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



28-29-97-9

FOR TITLE INSURANCE

01812