91-110-H-13-E
1-21-92 dlk

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

5

92034877

FILED

MAY 28 1992

AFFIDAVIT OF SURVIVORSHIP

Comes now GLYNDONA A. CAIN-GREVEN, being duly sworn upon her oath and states as follows:

Dora Antone
AUDITOR LAKE COUNTY

That the affiant is a daughter of Alonzo J. Cain and Bethellyn Cain, husband and wife, both of whom are deceased. That the said Alonzo J. Cain died on the 27th day of June, 1975, at St. Catherine Hospital, in East Chicago, Indiana; further, that the said Bethellyn Cain, deceased, died on the 30th day of March, 1991, and was at the time of her death the surviving widow of her husband, Alonzo J. Cain, deceased.

165661

TICOR TITLE INSURANCE
Crown Point, Indiana

That the said Alonzo J. Cain and the said Bethellyn Cain, deceased, were husband and wife at the time of death of the said Alonzo J. Cain, deceased, and that Bethellyn Cain became the owner of the following described parcel of real estate on the death of Alonzo J. Cain:

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED FOR RECORD
JUN 2 8 59 AM '92
ROBERT ... RECORDER

> Lot 9 in Sheridan Park Addition to Whiting, as per plat thereof, recorded in Plat Book 4, page 18, in the Office of the Recorder of Lake County, Indiana.

That the said Bethellyn Cain acquired title, as joint tenants with right of survivorship, to said real estate on the date of death of the said Alonzo J. Cain and that the said Bethellyn

03840
14.00
tc

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

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.

91-110-H-13-D
Harry Kneifel

16506

CITY OF EAST CHICAGO, INDIANA
DEPARTMENT OF HEALTH
CITY HALL

Local Record of Death

THIS IS TO CERTIFY,
That our records show [illegible] died
June (MONTH) 27 (DAY) 1975 (YEAR) [illegible] (PLACE) Hospital & Hpe, Indiana (STREET, HOSPITAL)

Age at Death 55 Years Sex Male Married X Widowed
Birth Date 9 (Month) 9 (Day) 1919 (Year) Color White Single Divorced

Primary cause of death given was Adeno Carcinoma of Right Lung

Signed by Jose L. R. Ravelo, M.D. (Physician) Hammond, Ind. (Address)

Place of burial or removal Mater Dolorosa (Name of Cemetery) Owensboro, Kentucky

Date of burial 7-2-75 Funeral Director Robb & Pigg Whiting, Indiana (Address)

Signed E. A. Campagna Jr. D. Sec'y.

at East Chicago, Indiana 4-2-79 (Date)

Filed 7-9-75 01811

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

CERTIFICATE OF DEATH

Local No. 252

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

Franklin D. Remudaos M.D.

APR 04 1991
Date Issued

Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Bethellyn 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 U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: –
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] 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): 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 Matress Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Whiting
13d. STREET AND NUMBER: 1812 Oliver Avenue
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): Smith Miles
19. MOTHER'S NAME (First, Middle, Maiden Surname): Gola Brown

INFORMANT

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

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or 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?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: John P. Fife
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

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Cancer of the Lung
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.

Approximate Interval Between Onset and Death:

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):
[X] 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: S. Makam
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

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Remudaos M.D.
32. DATE FILED (Month, Day, Year): APR 04 1991

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) If yes, specify driver, passenger, pedestrian, etc.

018.12

FOR TITLE INSURANCE Crown Point, Indiana

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1