



COMMUNITY TITLE COMPANY

- An Indiana Corporation -
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

L 5769

93015221

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

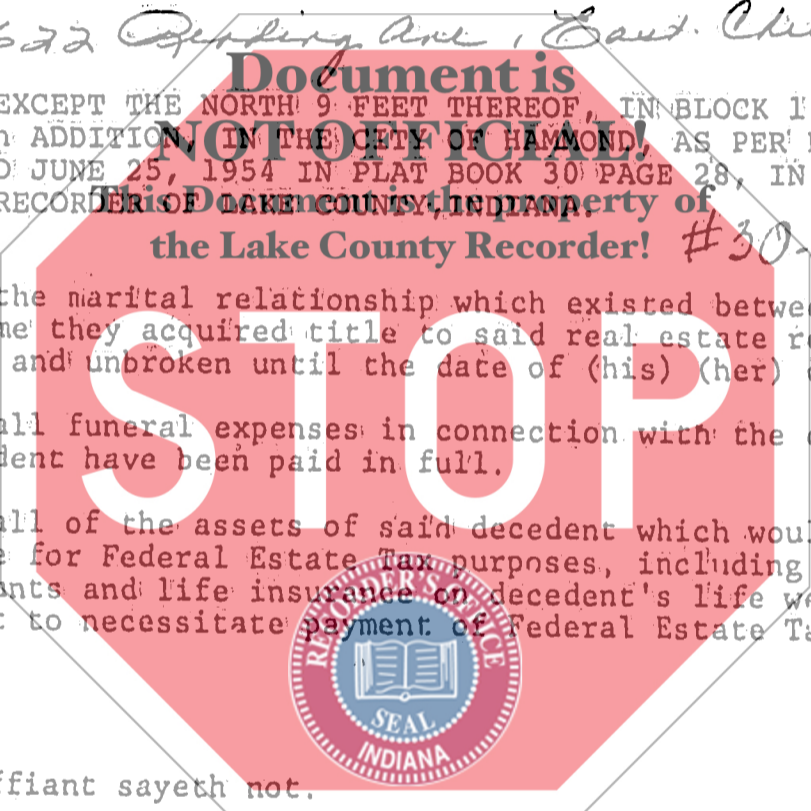
AKA PAULINE N. LEIGH

Pauline Leigh, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Edward Leigh a/k/a EDWARD L. LEIGH died (without leaving a will) (leaving a will) on April 28 19 91 at St. Catherine Hospital, East Chicago, Ind.
2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

5672 Appleby Ave, East Chicago, Ind.

LOT 9, EXCEPT THE NORTH 9 FEET THEREOF, IN BLOCK 1 IN ROXANA PARK 5th ADDITION, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED JUNE 25, 1954 IN PLAT BOOK 30 PAGE 28, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

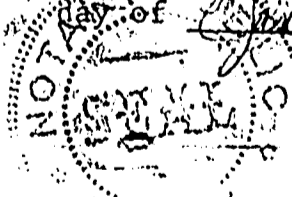


3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Pauline Leigh

Subscribed and sworn to before me, a Notary Public, this 26th day of January, 1993.



Janet K. Meyer
Notary Public
JANET K. MEYER

My Commission expires:

Aug. 12, 94

County of Residence:

Lake

FEB 19 1993

Anna N. Anton
AUDITOR LAKE COUNTY

This Instrument prepared by Mark D. Duce

01055

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD

MAR 9 11 39 AM '93
SARUCEL ORLICH
RECORDER

See on

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 121

State No.

TYPE/PRINT IN! PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1 DECEASED--NAME (First Middle Last) EDWARD L. LEIGH		2 SEX MALE	3a TIME OF DEATH 11:30 AM	3b DATE OF DEATH (Month Day Year) APRIL 28, 1991
4 SOCIAL SECURITY NUMBER 495-32-5538	5a AGE--Last Birthday (Years) 65	5b UNDER 1 YEAR Mornings Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) April 16, 1926
7 BIRTHPLACE (City and State or Foreign Country) Ridgely, Tennessee	8a WAS DECEDENT A US VETERAN? Yes			
8b YEAR LAST SERVED IN US ARMED FORCES? 1947	9a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) St. Catherine Hospital	9c CITY TOWN OR LOCATION OF DEATH East Chicago	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If not, give maiden name) Pauline Crum	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Roller #1 Coal Strip	12b KIND OF BUSINESS/INDUSTRY Inland Steel	
13a RESIDENCE--STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION East Chicago	13d STREET AND NUMBER 5622 Reading Street	
13e ZIP CODE 46312	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) Elementary/Secondary (10-12) 12 College (1-4 or 5+) 2		18 FATHER'S NAME (First Middle Last) Jack Leigh		
19 MOTHER'S NAME (First Middle Maiden Surname) Mary Nell Lewis		20a INFORMANT'S NAME (Type/Print) Mrs. Pauline Leigh		
20b MAINING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5622 Reading St. East Chicago, IN 46312		20c Relationship Wife		
21a 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)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) May 1, 1991 Memorial Home Cemetery Park		21c LOCATION--City or Town, State Schererville, Indiana
22a EMBALMER'S NAME David McCoy		22b EMBALMER'S LICENSE NO. FDO8700581	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>John C. [Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO1013507	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323	
26 PART I Enter the disease, 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. CARDIOGENIC SHOCK DUE TO (OR AS A CONSEQUENCE OF) ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF) DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF)				Approximate Interval Between Onset and Death FEB 19 1993 <i>David N. Anton</i>
26 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)?
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>[Signature]</i>		29c MEDICAL LICENSE NO. 01025435
29d DATE SIGNED (Month, Day, Year) April 29, 1991		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) T. W. Raykovich, M.D. 2450-169th St. Hammond, IN 46323		
31 HEALTH OFFICER'S SIGNATURE <i>T. W. Raykovich</i>				32 DATE FILED (Month, Day, Year) 4-29-91
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		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) 01050		34g DATE PRONOUNCED DEAD (Month, Day, Year)		
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc				

