COMMUNITY TITLE COMPANY

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

93042324

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Teressa B. Dye, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Philip D. Dye died (without leaving a will) (~~xxxxxxxxxxxxxxxx~~) on September 11, 19 90 at 3200 Michigan Ave, Hammond, IN. (Auto accident)

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

18-235-14

Lot 14 in Block 1 in Villa Shores Sixth Addition to Hobart, as per plat thereof, Recorded April 14, 1953 in Plat Book 29, Page 101, in the Office of the Recorder of Lake County, Indiana.

JUN 30 AM 26 AM '93
SAMUEL ORLICH
RECORDER

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

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.

Teressa B. Dye
Teressa B. Dye

Subscribed and sworn to before me, a Notary Public, this 20th day of May, 1993.

Daniel W. Slusser
Notary Public

My Commission expires:
8/3/96

County of Residence:
Lake

NOTARY PUBLIC STATE OF INDIANA

FILED
JUN 25 1993
AUDITOR LAKE COUNTY

This Instrument prepared by Teressa B. Dye

01370

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

Sept 19, 1990 — Date Issued — Hammond Health Commissioner

Cal No. A 780

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

CEDENT

1 DECEASED—NAME (First, Middle, Last): PHILIP D. DYE
2 SEX: MALE
3a TIME OF DEATH: 11:05 PM
3b DATE OF DEATH (Month, Day, Year): SEPTEMBER 11, 1990
4 SOCIAL SECURITY NUMBER: 305-62-3736
5a AGE—Last Birthday (Years): 37
6a UNDER 1 YEAR (Months, Days):
6b UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Month, Day, Year): SEPT. 12, 1952
7 BIRTHPLACE (City or Town, State or Foreign Country): HAMMOND, INDIANA
8a WAS DECEDENT A U.S. VETERAN?: YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: UNAVAILABLE
9a PLACE OF DEATH (Check only one): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Other (Specify): AUTOMOBILE ACCIDENT ☐ Residence
9b FACILITY NAME (If not institution, give street and number): 3200 MICHIGAN AVENUE
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): TERESSA B. FIELDS
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CHEMICAL OPERATION
12b KIND OF BUSINESS/INDUSTRY: RHONE-POULENC
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN, OR LOCATION: HOBART
13d STREET AND NUMBER: 347 NORTH COLORADO STREET
13e ZIP CODE: 46342
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): 10TH; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): OMER DYE
19 MOTHER'S NAME (First, Middle, Maiden Surname): MARY DEREMIAH

INFORMANT

20a INFORMANT'S NAME (Type/Print): TERESSA B. DYE
20b MAILING ADDRESS (Street and Number or R.F.D. Number, City or Town, State, Zip Code): 347 NORTH COLORADO ST. HOBART, IN 46342
20c RELATIONSHIP: SPOUSE

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): SEPTEMBER 16, 1990
21c LOCATION—City or Town, State: CHAPEL LAWN MEMORIAL GARDENS SCHERERVILLE, INDIANA
22a EMBALMER'S NAME: JAMES W. GHOLSTON
22b EMBALMER'S LICENSE NO.: FD01004194
23 WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b LICENSE NUMBER (of Licensee): FD01006463
24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOMES, INC. FH83003069 600 W. RIDGE RD, HOBART, IN 46342

CAUSE OF DEATH

25 PART I. Enter the disease, injury, or complications that caused the death. Do not enter terminal events such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Appx. Interval Onset to Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Multiple rib fractures with lacerations of the — Unknown
DUE TO (OR AS A CONSEQUENCE OF): b. aorta and liver
DUE TO (OR AS A CONSEQUENCE OF): c. Hemothorax and Hemoperitoneum
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): YES
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

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.

29c SIGNATURE AND TITLE OF CERTIFIER: Daniel L. Thomas MD
29d MEDICAL LICENSE NO.: 16120
29b DATE SIGNED (Month, Day, Year): Sept. 19, 1990
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): DANIEL THOMAS, MD, LAKE COUNTY CORONER, 2293 N. MAIN ST, CROWN POINT, IN 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Dr. Alan D. Freeman M.D.
32 DATE FILED (Month, Day, Year): SEP 19 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): Sept. 11, 1990
34b TIME OF INJURY: Unknown
34c INJURY AT WORK? (Yes or no): No
34d DESCRIBE HOW INJURY OCCURRED: Automobile accident
34e PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): Street
34f LOCATION (Street and Number or Rural Route Number, City or Town, State): 3200 Block of Michigan Avenue Hammond, Indiana
34g DATE PRONOUNCED DEAD (Month, Day, Year): September 11, 1990
34h MOTOR VEHICLE ACCIDENT? (Yes or no) - If yes specify driver, passenger, pedestrian, etc.: Yes — Driver

✓

SBH06 004 State Form 10110 (R2/3-88) (No Cert. Fee)