

93086301

COMMUNITY TITLE COMPANY  
FILE NO. 27259

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

**AFFIDAVIT**

NAOMI WALSH-FANSLER, being duly sworn upon her oath, states:

1. That she resides at 1510 172nd Place, Hammond, County of Lake, State of Indiana.

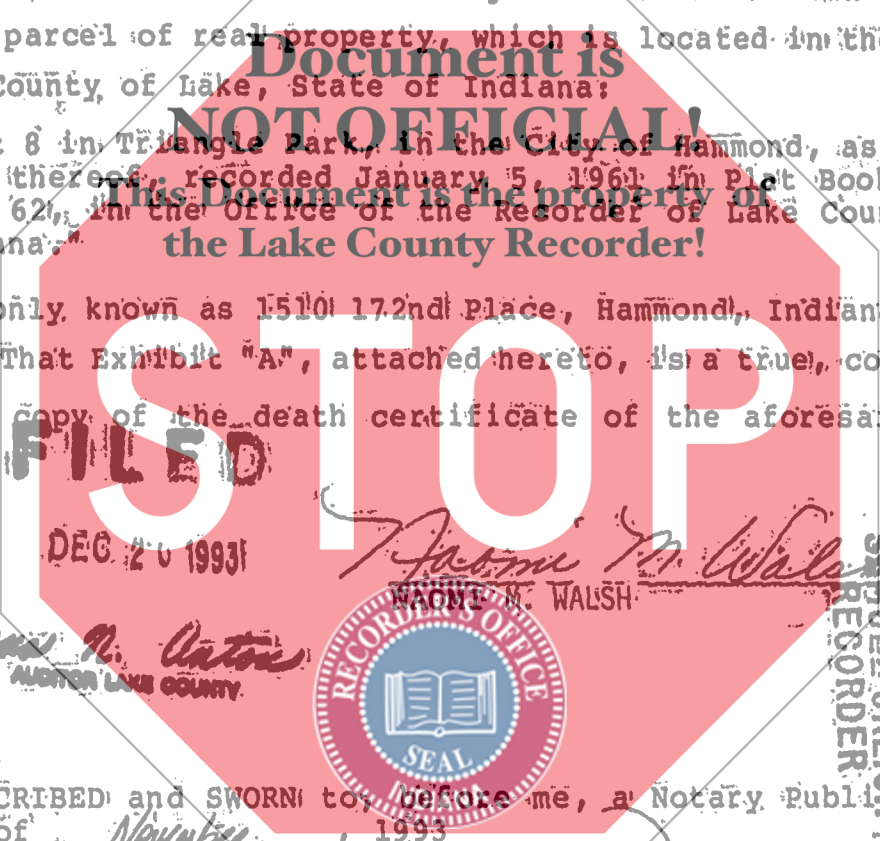
2. That she is the surviving widow of Donald Walsh, who died a resident of Hammond, Lake County, Indiana, on June 16, 1988.

3. That she is the surviving and exclusive owner of the following parcel of real property, which is located in the City of Hammond, County of Lake, State of Indiana:

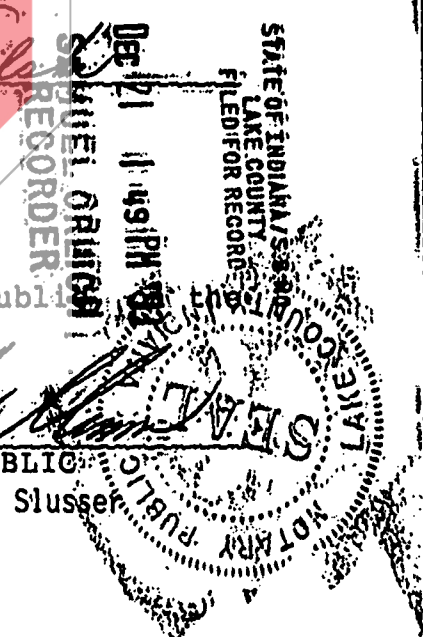
"Lot 8 in Triangle Park, in the City of Hammond, as per plat thereof, recorded January 5, 1961 in Plat Book 34 Page 62, in the Office of the Recorder of Lake County, Indiana."

Commonly known as 1510 172nd Place, Hammond, Indiana.

4. That Exhibit "A", attached hereto, is a true, correct and authentic copy of the death certificate of the aforesaid Donald Walsh.



*Ann R. Carter*  
AUDITOR LAKE COUNTY



SUBSCRIBED and SWORN to, before me, a Notary Public, on the 29<sup>th</sup> day of November, 1993

*Daniel W. Slusser*  
NOTARY PUBLIC

My Commission Expires: 8/3/96

County of Residence: Lake

This document prepared by William H. Walden, Attorney at Law, 8242 Calumet Ave., Ste. B, Munster, Indiana 46321

20519  
800  
8 CM

INDIANA STATE BOARD OF HEALTH

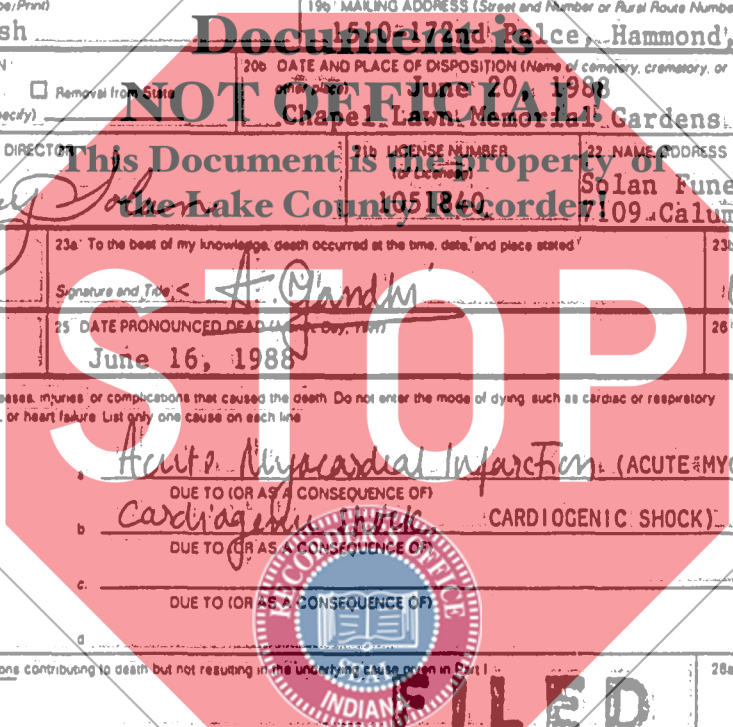
Local No. 1292-89

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME FIRST MIDDLE LAST <b>DONALD WALSH</b>	2 SEX <b>Male</b>		3 DATE OF DEATH (Mo Day Yr) <b>June 16, 1988</b>	
4 SOCIAL SECURITY NUMBER <b>305-20-1425</b>	5a AGE—Last Birthday (Years) <b>61</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) <b>July 30, 1926</b>
8 YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Incident <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution, give street and number) <b>Munster Community Hospital</b>	9c CITY TOWN OR LOCATION OF DEATH <b>Munster</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>Naomi Franklin</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Rigger</b>		12b KIND OF BUSINESS/INDUSTRY <b>ARCO Refinery</b>
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Hammond</b>	13d STREET AND NUMBER <b>1510-172nd Place</b>	
13e INSIDE CITY LIMITS? (Yes or no) <b>Yes</b>	13f FARM <b>no</b>	13g ZIP CODE <b>46324</b>	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17 FATHER'S NAME (First Middle Last) <b>Walter Walsh</b>	18 MOTHER'S NAME (First Middle Maiden Surname) <b>Catherine O'Keefe</b>			
19a INFORMANT'S NAME (Type/Print) <b>Naomi Walsh</b>	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1510-172nd Place, Hammond, In. 46324</b>		19c Relationship <b>Wife</b>	
20a 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)	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>June 20, 1988 Chapel Lawn Memorial Gardens</b>		20c LOCATION—City or Town, State <b>Schererville, Indiana</b>	
21a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony John</i>	21b LICENSE NUMBER (for license) <b>1051840</b>	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Solan Funeral Home #3002893 7109 Calumet Ave., Hammond, In. 46324</b>		
23a To the best of my knowledge, death occurred at the time, date, and place stated? Signature and Title: <i>A. Gandhi</i>	23b LICENSE NUMBER <b>01029887</b>	23c DATE SIGNED (Month, Day, Year) <b>6-17-88</b>		
24 TIME OF DEATH <b>11:30 a.m. M</b>	25 DATE PRONOUNCED DEAD (Month, Day, Year) <b>June 16, 1988</b>	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) <b>no</b>		
27 PART I Enter the disease, injuries or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction (ACUTE MYOCARDIAL INFARCTION)</b> <b>Cardiogenic Shock (CARDIOGENIC SHOCK)</b>	IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A CONSEQUENCE OF)	Approximate Interval Between Onset and Death <b>2 days</b> <b>1 day</b>	
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>no</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
THIS CERTIFIES THAT ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH AND THAT THE DECEASED WAS RESIDENT OF LAKE COUNTY, INDIANA AT THE TIME OF DEATH.				
29a SIGNATURE AND TITLE OF CERTIFIER <i>Beulah Johnson</i>	29b LICENSE NUMBER	29c DATE SIGNED (Month, Day, Year) <b>June 17, 1988</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Arvind Gandhi M.D., 9112 Columbia Ave., Munster, Indiana 46321</b>				
31 HEALTH OFFICER'S SIGNATURE <i>Beulah Johnson</i>	32 DATE FILED (Month, Day, Year) <b>6/17/88</b>			
33 MANNER OF DEATH <input checked="" 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"/> -omoc de	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)			



THIS CERTIFIES THE COMPLETE COPY OF THE CERTIFICATE OF DEATH AND THAT THE DECEASED WAS RESIDENT OF LAKE COUNTY, INDIANA AT THE TIME OF DEATH.

CERTIFIER JUN 17 1988

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

07520