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FILED

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

APR 9 1994

Carol N. Anton
AUDITOR LAKE COUNTY

AFFIDAVIT OF SURVIVORSHIP

94025867

Comes now FRED M. STULTS, JR., being duly sworn upon his oath, and states as follows:

That Virgil R. Cage and Elizabeth Mae Cage were owners in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

The West One-Half (1/2) of Lot Forty-Six (46), the West One-Half (1/2) of Lot Forty-Seven (47) and the West One-Half (1/2) of Lot Forty-Eight (48), Block 8, Reissig's Addition to Glen Park, commonly known as 310 W. 43rd Avenue, Gary, Indiana 46408 (Key No. 46-404-38).

That Virgil R. Cage and Elizabeth Mae Cage were married in 1925.

That the marital relationship which existed between Virgil R. Cage and Elizabeth Mae Cage continued unbroken from the time they acquired title to said real estate until the death of Virgil R. Cage on the 5th day of January, 1988, at which time, Elizabeth Mae Cage acquired title to the real estate as surviving joint tenant.

That the gross value of the estate of the decedent, Virgil R. Cage, as determined for the purpose of Federal Estate Taxes, was less than the value required for the filing of a Federal Estate Tax Return. As a consequence thereof, the decedent's estate was not subject to Federal Estate Tax.

That the decedent's estate was not subject to Indiana Inheritance Taxes.

That Elizabeth Mae Cage died on the 27th day of August, 1989.

That the Affiant is the son-in-law of Virgil R. Cage and Elizabeth Mae Cage.

Fred M. Stults Jr.
FRED M. STULTS, JR.

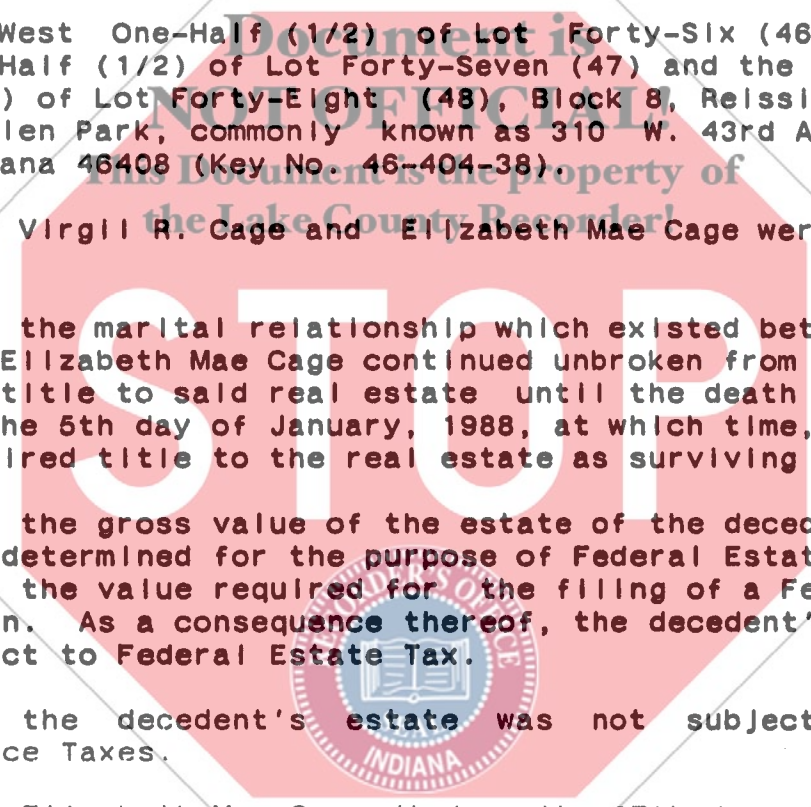
Subscribed and sworn to before me, a Notary Public in and for said County and State, this 6th day of August, 1993.

Doris House Madry
DORIS HOUSE MADRY, Notary Public
Resident of Lake County, IN

My Commission Expires:
9/14/96

*Fred M. Stults Jr.
3637 Grand St.
Gary, In. 46408*

90792 *jo*



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
APR 9 1994
RECEIVED
AUDITOR LAKE COUNTY

10100

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 410-88

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED-NAME FIRST MIDDLE LAST 2 SEX 3 DATE OF DEATH (Mo Day Year) VIRGIL ROSCOE CAGE M JAN. 5, 1988

4 SOCIAL SECURITY NUMBER 5a AGE - last birthday (Years) 5b UNDER 1 YEAR 5c UNDER 1 DAY 6 DATE OF BIRTH (Month Day Year) 7 BIRTHPLACE (City and State or Foreign Country) 310-03-4833 89 Months Days Hours Minutes 9-29-1898 ANDERSON, INDIANA

8 YEAR LAST SERVED IN U.S. ARMED FORCES? 9a PLACE OF DEATH (Check only one. See instructions) NEVER SERVED HOSPITAL [X] Inpatient [] ER Outpatient [] DOA [] OTHER [] Nursing Home [] Residence [] Other (Specify)

9b FACILITY NAME (If not institution give street and number) 9c CITY TOWN OR LOCATION OF DEATH 9d COUNTY OF DEATH ST. ANTHONY MEDICAL CENTER CROWN POINT LAKE

10 MARITAL STATUS - Married Never Married Widowed Divorced (Specify) 11 SURVIVING SPOUSE (If wife give maiden name) 12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) 12b KIND OF BUSINESS/INDUSTRY MARRIED ELIZABETH MAE SHAW SUPERVISOR U.S. STEEL-GARY WORKS

13a RESIDENCE-STATE 13b COUNTY 13c CITY TOWN OR LOCATION 13d STREET AND NUMBER INDIANA LAKE CROWN POINT 1079 S. MAIN STREET

13e RYSIDE CITY LIMITS? (Yes or no) 13f FARM 13g ZIP CODE 14 WAS DECEASED OF HISPANIC ORIGIN? (Specify No or Yes. If yes specify Cuban, Mexican, Puerto Rican, etc.) [X] No [] Yes Specify 15 RACE - American Indian, Black, White, etc. (Specify) 16 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary, Secondary (10-12) College (1-4 or 5+) YES NO 46307 WHITE

17 FATHER'S NAME (First Middle Last) 18 MOTHER'S NAME (First Middle Maiden Surname) EDWIN CAGE ALICE BEAMAN

19a INFORMANT'S NAME (Type/Print) 19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c Relationship ELIZABETH MAE CAGE 1079 S. MAIN STREET, CROWN POINT, IN 46307 WIFE

20a METHOD OF DISPOSITION: [X] Burial [] Cremation [] Removal from State [] Donation [] Other (Specify) 20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) 20c LOCATION - City or Town, State 1-7-88 CHESTERTON CEMETERY CHESTERTON, INDIANA

21a SIGNATURE OF FUNERAL DIRECTOR 21b LICENSE NUMBER (of Licensee) 22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Terrence P. Burns 123 BURNS FUNERAL HOME, Inc. 10101 BROADWAY, CROWN POINT, IN 46307

23a To the best of my knowledge, death occurred at the time, date and place stated. Signature and Title: Terrence P. Burns, M.D. 23b LICENSE NUMBER: C1035167 23c DATE SIGNED (Month Day Year): JAN. 5, 1988

24 TIME OF DEATH 25 DATE PRONOUNCED DEAD (Month Day Year) 26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) 4:10 A.M. 1/5/88 No

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. 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. Due to (or as a consequence of) Accidents APR 4, 1994 Anne N. Anton AUDITOR LAKE COUNTY

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) 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

29a CERTIFIER (Check only one) [X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. [] PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. [] MEDICAL EXAMINER [] CORONER [] 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d DATE SIGNED (Month Day Year) [Signature] 01030518 1-7-88

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

31 HEALTH OFFICER'S SIGNATURE 32 DATE FILED (Month Day Year) [Signature] JAN 8, 88

33 MANNER OF DEATH 34a DATE OF INJURY (Month Day Year) 34b TIME OF INJURY 34c INJURY AT WORK? (Yes or no) 34d DESCRIBE HOW INJURY OCCURRED [] Natural [] Pending Investigation [] Accident [] Suicide [] Could not be Determined [] Homicide 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)

FILED

