

Please Return To:

ARNOLD KREVITZ
Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

AMASA G. COLBY
CHIEF DEP. RECORDER

95002466

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JUANITA SCOTT, being first duly sworn upon her oath,
deposes and says:

1. That she was married to LEWIS SCOTT on August 6,
1959, who died a resident of Gary, Lake County, Indiana, on
September 7, 1989, as evidenced by a Certified Death Certificate
attached hereto and made a part hereof.

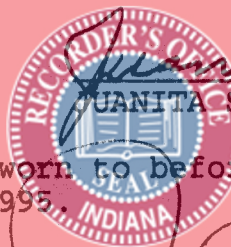
2. That at the time of his death, LEWIS SCOTT and
JUANITA SCOTT, Husband and Wife, held title under a Warranty Deed
to the following-described Real Estate, to-wit:

South 45' of Tract 33, Suburban
Acres, in the City of Gary, as per
plat thereof, recorded in Plat Book
23, page 13, in the Office of the
Recorder of Lake County, Indiana.

3. That the Affiant and the Decedent, LEWIS SCOTT,
were Husband and Wife continuously from the time they acquired
title to the above-described Real Estate to the time of his death
on September 7, 1989.

4. That the Estate of LEWIS SCOTT, decedent, was not
of sufficient value to be subject to Federal Estate Taxes or
Indiana Inheritance Taxes.

FURTHER AFFIANT SAYETH NOT.



JUANITA SCOTT

Subscribed and sworn to before me, a Notary Public,
this 9th day of January, 1995.

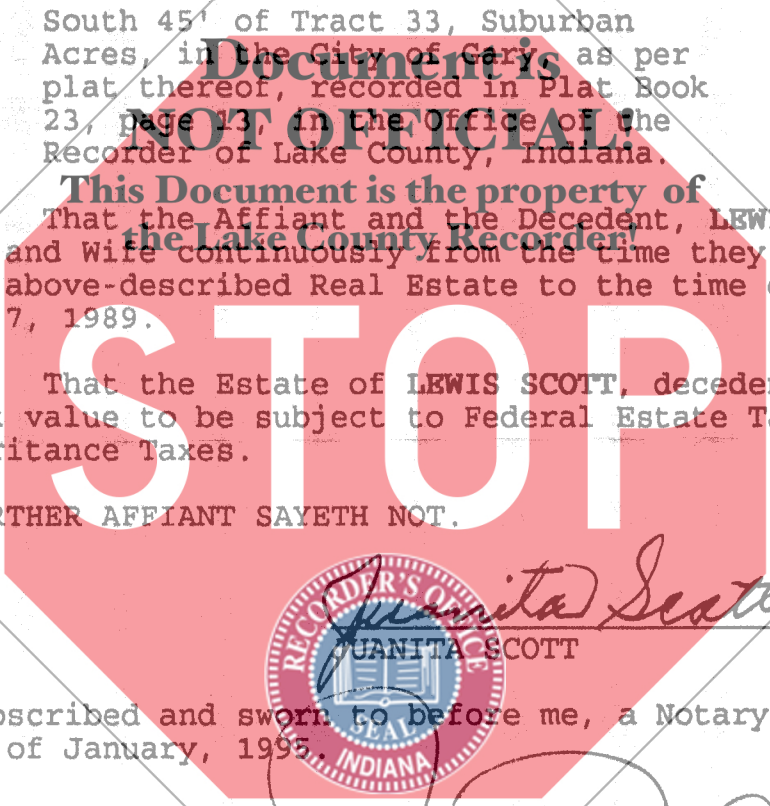
MARY P. COONS, Notary Public
Resident of Porter County

My Commission Expires:
January 6, 1997

This Instrument Prepared by: ARNOLD KREVITZ
Attorney At Law
500 East 86th Avenue
Merrillville, IN 46410
(219) 769-1300

95 JAN 12 PM 2:41

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD



FILED
JAN 12 1995
SAM ORLICH
AUDITOR LAKE COUNTY

000098

11.00

**INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH**

Local No. **4129-89**

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) LEWIS SCOTT		2 SEX MALE	3a TIME OF DEATH 04:30 P.	3b DATE OF DEATH (Month, Day, Year) SEPTEMBER 7, 1989
4 SOCIAL SECURITY NUMBER 309-12-7956	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo., Day, Yr.) June 15, 1920
7 BIRTHPLACE (City and State or Foreign Country) Clarksdale, Mississ	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Residence	
9a FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9b CITY, TOWN OR LOCATION OF DEATH Hobart	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Juanita Johnson	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Foreman	12b KIND OF BUSINESS/INDUSTRY U.S. Reduction	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 941 Colfax St.	
13e ZIP CODE 46406	14 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14a CITIZEN OF WHAT COUNTRY? USA	14b WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14c RACE—American Indian, Black, White, etc. (Specify) Afro. Amer.
15 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16 FATHER'S NAME (First, Middle, Last) Unknown		
17 MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Unknown		18 INFORMANT'S NAME (Type, Print) Juanita Scott		
19 MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 941 Colfax St. Gary, IN 46406		20 Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) September 12, 1989 Oakhill Cem		21c LOCATION—City or Town, State Gary, IN
22a EMBALMER'S NAME Sherman G. Banks 3rd		22b EMBALMER'S LICENSE NO. FDO1042607		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Eds. Wain</i>		24b LICENSE NUMBER (of Licensee) FDO 1042607		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Smith Bizzell & Warner FDH 3002487 2295 Washington St. Gary 46407
26 PART I: Enter the disease, injury, 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. Intra cerebral hemorrhage		THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.		
IMMEDIATE CAUSE (Final disease or condition resulting in death) hypertension		Approximate Interval Between Onset and Death JAN 09 1995		
Conditions if any which gave rise to the immediate cause stating the underlying cause last 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		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No		
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I.		28a WAS AN AUTOPSY PERFORMED? (Yes or No) No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) N/A
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. 03102651		29d DATE SIGNED (Month, Day, Year) September 8, 1989		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Dr. Vijay Dave 202 East 86th Place Merrillville, IN 46410				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32 DATE FILED (Month, Day, Year) OCT 18 89		
33 MANNER OF DEATH <input 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"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or No)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE INJURY OCCURRED		
34f LOCATION (Street, City or Town, State)		34g LOCATION (Street, City or Town, State)		
34h DATE PRONOUNCED DEAD (Month, Day, Year)		34i MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.		



FILED
JAN 12 1995
SAM ORLICK
AUDITOR LAKE COUNTY

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY