

**FILED**

**JAN 26 1995**

STATE OF INDIANA )

3 COUNTY OF LAKE )

) SS:

SAM ORLICH  
AUDITOR LAKE COUNTY

**AFFIDAVIT OF PHYLLIS J. BURFIELD**

Phyllis J. Burfield, being first duly sworn upon oath, deposes and says:

1. That I was the wife of James E. Burfield who died on February 13, 1993.
2. That a certified copy of the Death Certificate of James E. Burfield is attached to this Affidavit.
3. That at the time of James E. Burfield's death, title to the following described real estate located in Lake County, Indiana:

**Document is NOT OFFICIAL!**  
 This Document is the property of the Lake County Recorder.  
 The North 24 feet of lots 12 and the South 16 feet of Lot 13 in Block 7 in Forsyth Highlands 2nd Addition, Hammond, as per plat thereof, recorded in Plat Book 18, page 11, in the Office of the Recorder of Lake County, Indiana.

was held in the following names: James E. Burfield and Phyllis J. Burfield, husband and wife.

4. That James E. Burfield and I acquired title to said real estate as husband and wife by a deed dated 8-31-56 and recorded October 6, 1956 in the Office of the Recorder of Lake County, Indiana in Deed Book 1042, page 147.
5. That James E. Burfield and I remained husband and wife continuously from the date we acquired title to said real estate until the date of his death on February 13, 1993.
6. That any Indiana inheritance tax or federal estate tax due or payable as a result of the death of James E. Burfield has been or will be paid.
7. That I affirm under the penalties for perjury that the above statements are true and that I am over the age of 18 years and am competent to make this Affidavit.

*Phyllis J. Burfield*  
Phyllis J. Burfield

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for said County

MARGARETTEN CLEVELAND  
LAKE COUNTY RECORDER  
95004631

95 JAN 26 AM 11:26

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

001145

1000

and State, this 24<sup>th</sup> day of JANUARY, 1995

David C. Lutz

Notary Public

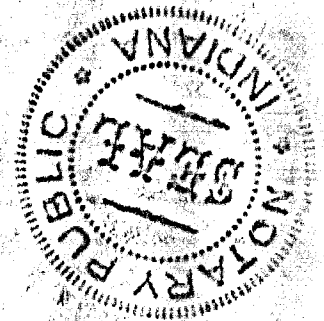
My County of Residence is:

Lake, Indiana

My Commission Expires:

8/16/97

This documents was prepared by: Mary P. Bottum, 328 N. Michigan St., South Bend, IN 46601



David Lutz  
927 Maxwell Court  
Groun Point 246307

**INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH**

THIS CERTIFIES THE FOLLOWING IS A TRUE AND  
CORRECT COPY OF DEATH ON FILE WITH THE  
INDIANA STATE DEPARTMENT OF HEALTH

Local No. **138**

Filed **Feb 16 1993**  
Date Signed **Sam Orllich**  
Name and Title of Auditor

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-9

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

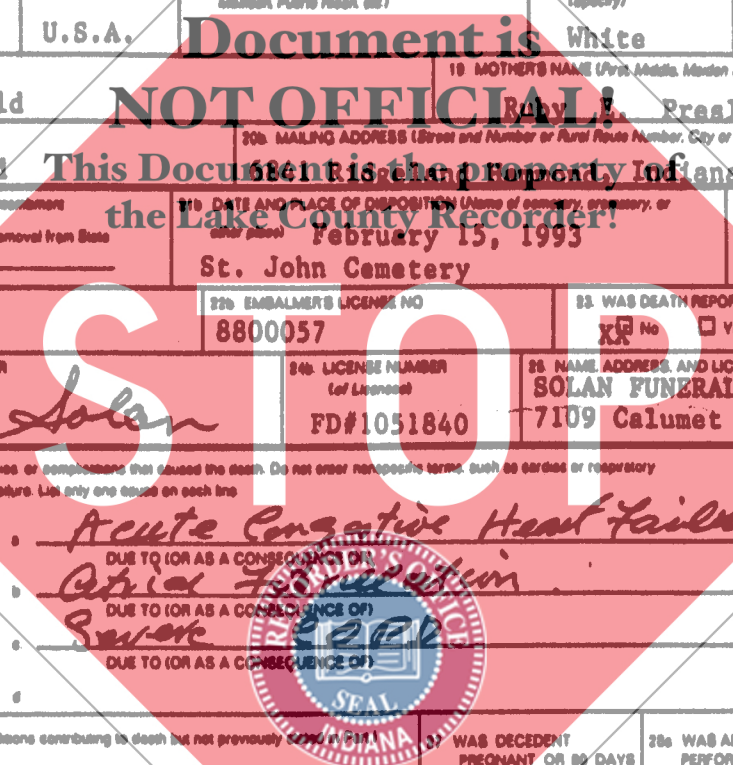
CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

CORONER  
USE ONLY

1 DECEASED—NAME (First Middle Last) <b>JAMES E. BURFIELD Sr.</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>8:30 AM</b>	3b DATE OF DEATH (Month Day Year) <b>February 13, 1993</b>
4 SOCIAL SECURITY NUMBER <b>309-24-7998</b>	5a AGE—Last Birthday (Year) <b>63</b>	5b UNDER 1 YEAR Month: _____ Days: _____	5c UNDER 1 DAY Hour: _____ Minute: _____	6 DATE OF BIRTH (Month Day Year) <b>July 23, 1929</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Illinois</b>	8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1955</b>	9a PLACE OF DEATH (Check only one for residence) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> In/Outpatient <input type="checkbox"/> POA <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution give street and number) <b>St. Margaret Hospital</b>		9c CITY, TOWN, OR LOCATION OF DEATH <b>Hammond</b>	9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If not, give maiden name) <b>Phyllis Shoemaker</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Gas Serviceman</b>	12b KIND OF BUSINESS/INDUSTRY <b>NIPSCO</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>6841 Ridgeland</b>	
15a ZIP CODE <b>46324</b>	15b INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	16 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17 DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12) College (11-4 or 6+)</b>		<b>12 years</b>		
18 FATHER'S NAME (First Middle Last) <b>Walter Burfield</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>Ruby E. Presley</b>		
20a INFORMANT'S NAME (Type/Print) <b>Phyllis Burfield</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Indiana 46324</b>	20c Relationship <b>Wife</b>	
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) <b>February 15, 1993 St. John Cemetery</b>		21c LOCATION—City or Town, State <b>Hammond, Indiana</b>
22a EMBALMER'S NAME <b>Dean G. Wagner</b>		22b EMBALMER'S LICENSE NO. <b>8800057</b>	22c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony Solan</i>		24b LICENSE NUMBER (of Licensee) <b>FD#1051840</b>	24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>SOLAN FUNERAL HOME PH# 83002893 7109 Calumet Ave., Hammond, Ind. 46324</b>	
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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Acute Congestive Heart Failure</b>				
DUE TO (OR AS A CONSEQUENCE OF) <b>Chronic Hypertension</b>				
DUE TO (OR AS A CONSEQUENCE OF) <b>Stroke</b>				
DUE TO (OR AS A CONSEQUENCE OF)				
PART II. Other significant conditions - Conditions contributing to death but not previously stated (1-519)				
27a 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.		27b WAS DEATH REPORTED TO CORONER? <b>NO</b>		
<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.		27c WAS AN AUTOPSY PERFORMED? <b>NO</b>		
<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.		27d WAS AN AUTOPSY PENDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) <b>NO</b>		
28a SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		28b MEDICAL LICENSE NO. <b>16030-B</b>	28c DATE SIGNED (Month Day Year) <b>February 15, 1993</b>	
29 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Murray Stasick M.D. 7330 Indianapolis Blvd. Hammond, Indiana 46324</b>				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month Day Year) <b>February 16, 1993</b>
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 PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED <b>0</b>		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>00118</b>				
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		



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JAN 26 1993  
SAM ORLICH  
AUDITOR LAKE COUNTY