

TICOR MD

192161

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA

COUNTY OF LAKE

SS:

2

aka Mary P. Muir

MARY MUIR, being first duly sworn upon oath, deposes and says:

1. That LEONARD J. MUIR died on April 5,
1994, at Gary, Indiana.

aka Mary P. Muir

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

25-46-120-6+7

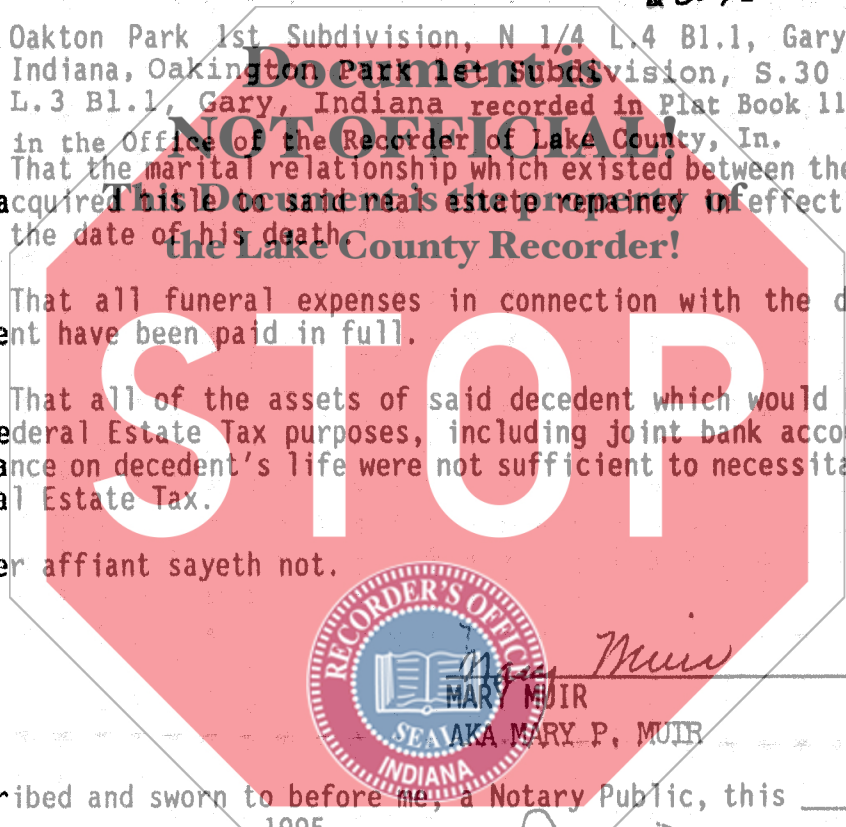
Oakton Park 1st Subdivision, N 1/4 L.4 Bl.1, Gary, Indiana, Oakington Park 1st Subdivision, S.30 ft. L.3 Bl.1, Gary, Indiana recorded in Plat Book 11 page 12, in the Office of the Recorder of Lake County, In.

3. That the marital relationship which existed between them at the time they acquired this real estate remains in effect and unbroken until the date of his 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.



Mary Muir
MARY MUIR
AKA MARY P. MUIR

Subscribed and sworn to before me, a Notary Public, this 25th day of May, 1995.

Paula Barrick

Paula Barrick

Notary Public

County of Residence: Lake
My Commission Expires 10-2-97

FILE

JUN 2 1995

This instrument prepared by:

JOHN D. BRECLAW & ASSOCIATES
By: ROBERT L. TAYLOR
Attorney I.D. No. 1787-45
200 West Glen Park Avenue
Griffith, Indiana 46319
(219) 972-6000

SAM ORLICH
CLERK FOR LAKE COUNTY

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95031364

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

95 JUN -5 AM 9:09

RECORDER

ATTENTION ESTATE: Disclosure of the information on this form is required by law. If you do not provide the information requested, the information you do provide may be incomplete and there will be no penalty for "usual."

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

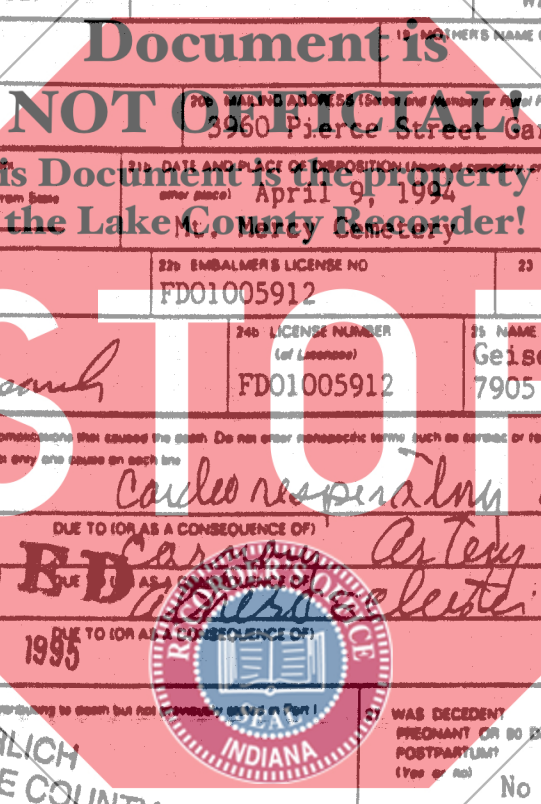
State No.

Cal No. **94-0264**

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Leonard James Muir		2 SEX Male	3a TIME OF DEATH 4:55 P	3b DATE OF DEATH (Month Day Year) April 5, 1994
4 SOCIAL SECURITY NUMBER 306-09-4353	5a AGE—Last Birthday (Years) 81	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) April 18, 1912
7 BIRTHPLACE (City and State or Foreign Country) Old Forge, Pennsylvania	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? -	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a FACILITY NAME (If applicable, give street and number) 3960 Pierce Street		9b CITY/TOWN OR LOCATION OF DEATH Gary		9c COUNTY OF DEATH Lake
10 MARITAL STATUS Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mary Jones	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Hot Saw Operator		12b KIND OF BUSINESS/INDUSTRY Steel Industry
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY/TOWN OR LOCATION Gary	13d STREET AND NUMBER 3960 Pierce Street	
14a ZIP CODE 46408	14b INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14c ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14d CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 (10-12) 7 College (1-4 or 5+) -		
18 FATHER'S NAME (First Middle Last) Robert Muir		19 MOTHER'S NAME (First Middle Maiden Surname) Helen Harvey		
20a INFORMANT'S NAME (Type/Print) Mary Muir		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3960 Pierce Street, Gary, IN 46408		20c Relationship Wife
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematorium, or other place) April 9, 1994, Holy Cross Cemetery		21c LOCATION—City or Town, State Gary, Indiana
22a EMBALMER'S NAME Ronald J. Mesarch		22b EMBALMER'S LICENSE NO. FDO1005912		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mesarch</i>		24b LICENSE NUMBER (of Licensee) FDO1005912		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410
26 PART I: Enter the disease, injuries, or conditions 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. Cardio respiratory arrest DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF) Abuse: alcohol, cocaine, drugs DUE TO (OR AS A CONSEQUENCE OF) _____ DUE TO (OR AS A CONSEQUENCE OF) _____				
27 PART II: Other significant conditions, conditions contributing to death but not immediately listed in Part I. SAM ORLICH AUDITOR LAKE COUNTY				
28a 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.		29c MEDICAL LICENSE NO. 02000324		29d DATE SIGNED (Month Day, Year) 4-8-94
29a SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29b NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Streeter Medical Surgical, P.C. 119 E. 89th Avenue Merrillville, IN 46410 Phone (219) 769-6221 Fax (219) 469-7609 Tax I.D.: 35-1499098		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <i>[Signature]</i>		31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		
32 DATE FILED (Month Day, Year) 4-8-94		33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigator <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 LOCATION (Street and Number or Rural Route Number, City or Town, State)		
35 DATE PRONOUNCED DEAD (Month Day, Year)		36 MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		



DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

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