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TICOR TITLE INSURANCE

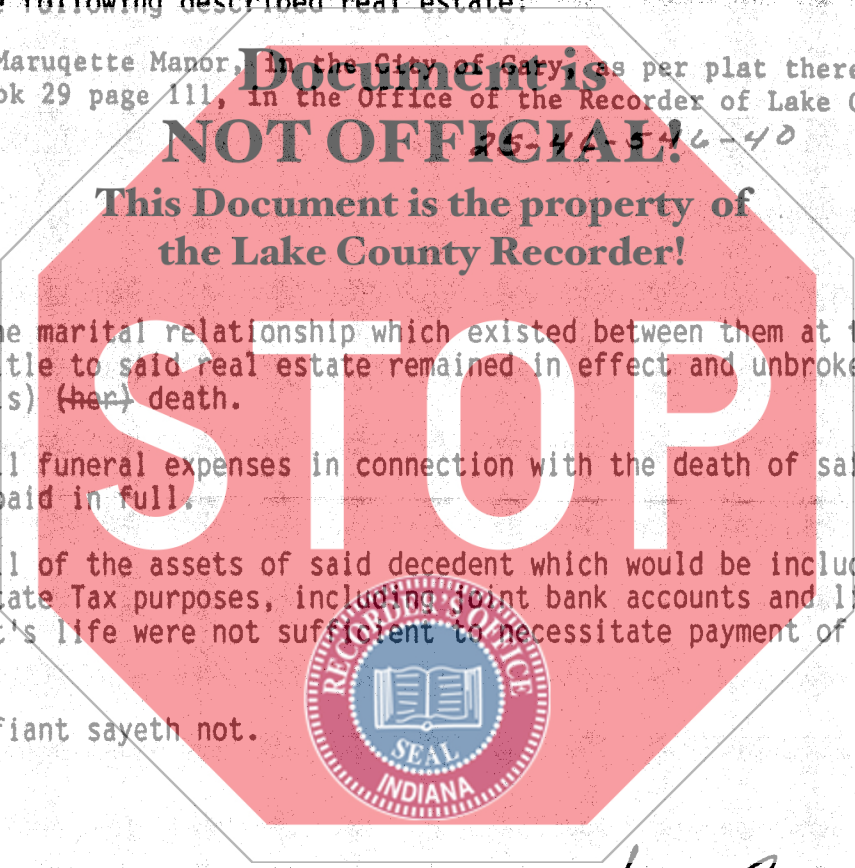
AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Inez R. Anderson, being first duly sworn upon oath, deposes and says:

1. That F. Laurence Anderson, Jr. died on March 6, 1991, 1991 at Methodist (Northlake) Gary, Indiana, Hospital
2. That F. Laurence Anderson, Jr. and Inez R. Anderson were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 40 in Marquette Manor, in the City of Gary, as per plat thereof, recorded in Plat Book 29 page 111, in the Office of the Recorder of Lake County, Indiana.



3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) 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.

Inez R. Anderson
Inez R. Anderson

Subscribed and sworn to before me, a Notary Public, this 13th day of October, 1995.

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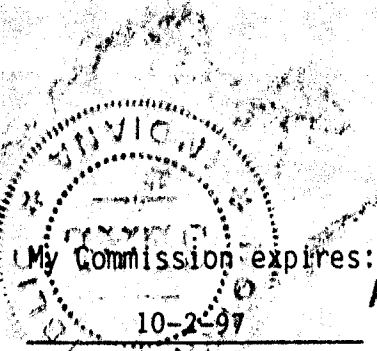
LAKE COUNTY
FILED FOR RECORD

MARGARET E. LEAND
RECORDER

FILED

OCT 17 1995

Paula Barr
Paula Barrick Notary Public



**SAM ORLICH
AUDITOR LAKE COUNTY**

County of Residence:
Lake

This Instrument prepared by Inez R. Anderson

000957

11/00/95

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

91-0200

State No.

TYPE/PRINT IN PERMANENT BLACK INK
DECEDENT
PARENTS
INFORMANT
DISPOSITION
CAUSE OF DEATH
CERTIFIER
HEALTH OFFICER
CORONER USE ONLY

1. DECEASED—NAME (Print Middle Last) F. Laurence Anderson				2. SEX Male	3a. TIME OF DEATH 5:45 p.m.	3b. DATE OF DEATH (month, day, yr) March 6, 1991
4. SOCIAL SECURITY NUMBER 304-14-8035		5a. AGE—Last Birthday (Years) 73	5b. UNDER 1 YEAR Months Days None None	5c. UNDER 1 DAY Hours Minutes None None	6. DATE OF BIRTH (Month, Day, Yr) October 8, 1917	7. BIRTHPLACE (City and State or Foreign Country) Utica, Mississippi
8a. WAS DECEASED A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9a. FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake			9b. CITY, TOWN, OR LOCATION OF DEATH Gary	9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS Married	11. SURVIVING SPOUSE (If not, give name) Inez R. Rempson		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work) Attorney		12b. KIND OF BUSINESS/INDUSTRY Self-employed	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Gary		13d. STREET AND NUMBER 6525 Birch Place		
15a. ZIP CODE 46403	15b. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	16. WAS DECEASED 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) Black	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secretary (9-12) College (1-4 or 5+) 7 years		18. FATHER'S NAME (Print Middle Last) F. Laurence Anderson				
19. MOTHER'S NAME (Print Middle Maiden Surname) Addie Hendley		20a. INFORMANT'S NAME (Type/Print) Inez R. Anderson		20b. MARITAL STATUS (Same as Decedent) 6525 Birch Place Gary, Indiana 46403	20c. 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. LOCATION—City or Town, State Hobart, Indiana		21c. DATE AND TIME OF DEATH March 11, 1991		
22a. EMBALMER'S NAME Roosevelt Allen Sr.		22b. EMBALMER'S LICENSE NO. #01051696	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Walter Broderick</i>		24b. LICENSE NUMBER (If Licensed) 08700646	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 83007704 Gay & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404			
26. PART I: Enter the disease, injuries, or conditions that caused the death. Do not enter non-specific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Respiratory Failure DUE TO IOR AS A CONSEQUENCE OF: Extensive Coronary Infarction DUE TO IOR AS A CONSEQUENCE OF: Dehydration DUE TO IOR AS A CONSEQUENCE OF: Dysphagia						
26. PART II: Other significant conditions - Conditions contributing to death but not previously stated. Aspiration Pneumonia Malnutrition Status Post Bilateral Above Knee Amputation						
27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) no						
28. WAS AN AUTOPSY PERFORMED? (Yes or no) no						
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) no						
30. 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.						
31. SIGNATURE AND TITLE OF CERTIFIER <i>Georgia B. Mitchell</i>				32. MEDICAL LICENSE NO. 01018611	33. DATE BORN (Month, Day, Year) 3-14-91	
34. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Georgia B. Mitchell, M.D. 3195 Broadway Gary, IN 46409						
35. HEALTH OFFICER'S SIGNATURE <i>Robert A. ...</i>						
36. DATE FILED (Month, Day, Year) MAR 18 1991						
37. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		38a. DATE OF INJURY (Month, Day, Year)	38b. TIME OF INJURY	38c. INJURY AT WORK? (Yes or no)	38d. DESCRIBE HOW INJURY OCCURRED	
39. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		39. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
39a. DATE PRONOUNCED DEAD (Month, Day, Year)		39b. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				



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