FA-16009

HOLD FOR FIRST AMERICAN TITLE

AFFIDAVIT

Joseph O'Connor, being duly sworn on his oath, states:

1. That I am an attorney-at-law with offices located at 5272 Hohman Avenue, Hammond, Indiana.

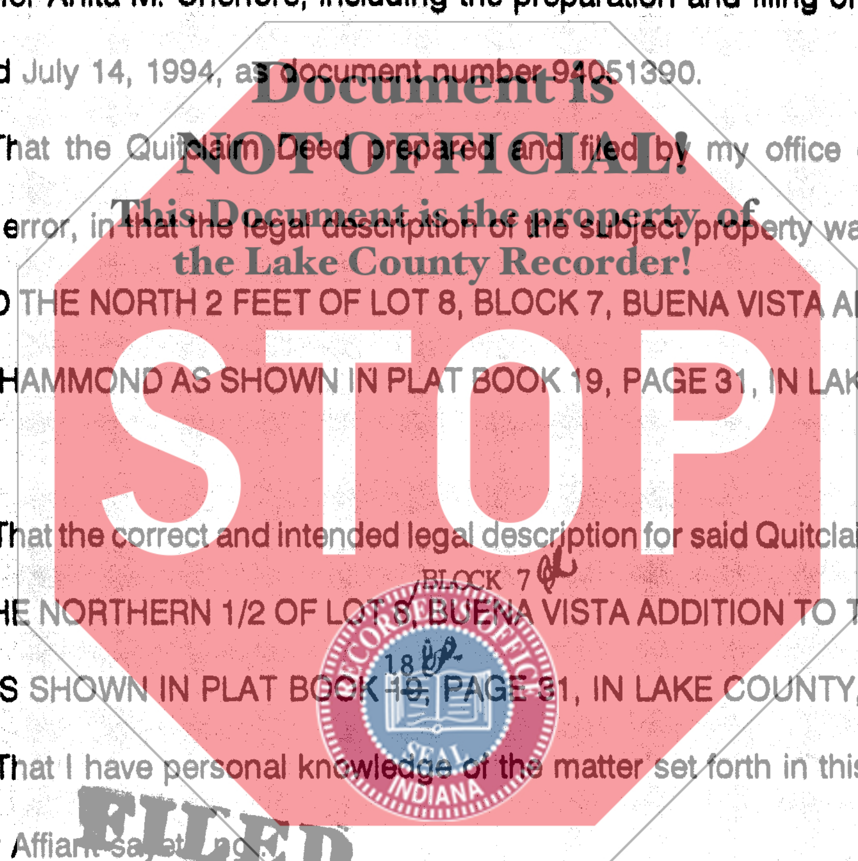
2. That in the course of my practice, during the year 1994, I performed various legal services for Anita M. Chenore, including the preparation and filing of a Quitclaim Deed recorded July 14, 1994, as document number 94051390.

3. That the Quitclaim Deed prepared and filed by my office contained a typographical error, in that the legal description of the subject property was described as "LOT 7 AND THE NORTH 2 FEET OF LOT 8, BLOCK 7, BUENA VISTA ADDITION TO THE CITY OF HAMMOND AS SHOWN IN PLAT BOOK 19, PAGE 31, IN LAKE COUNTY, INDIANA".

4. That the correct and intended legal description for said Quitclaim Deed was LOT 7 AND THE NORTHERN 1/2 OF LOT 8, BLOCK 7 BUENA VISTA ADDITION TO THE CITY OF HAMMOND AS SHOWN IN PLAT BOOK ~~19~~ 18, PAGE 31, IN LAKE COUNTY, INDIANA.

5. That I have personal knowledge of the matter set forth in this Affidavit.

Further Affiant sayeth not.



95067333

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 NOV -3 AM 10:24
MARGARET CLEMENTS
RECORDER

FILED
NOV 3 1995
SAM ORLICH
AUDITOR LAKE COUNTY

Joseph O'Connor

Subscribed and sworn to before me, a Notary Public, this 26th day of October, 1995.

Cori J. Petropoulos

My Commission Expires: 5/18/99

000313

708361738 SWANSON&BROWN 486 P02 OCT 26'95 11:15

ALTERNATIVE ... SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 328

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

COMPLETE COPY OF DEATH ... HAMMOND HEALTH DEPARTMENT.

SEP 12 1995 — Date Issued — Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ANITA M. CHENORE
2. SEX: Female
3a. TIME OF DEATH: 12:15 Pm
3b. DATE OF DEATH (Month Day Yr): May 1, 1995
4. SOCIAL SECURITY NUMBER: 315-09-2697
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): March 13, 1919
7. BIRTHPLACE (City and State or Foreign Country): Beaverville, Illinois
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: ------
9a. PLACE OF DEATH (Check only one; See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 7219 Howard Avenue
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widow
11. SURVIVING SPOUSE (If wife, give maiden name): None
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Own
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 7219 Howard Street
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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 (0-12): 12th; College (1-4 or 5+): ------

PARENTS

18. FATHER'S NAME (First, Middle, Last): Moses Dionne
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ludivine Regnier

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Darrel Chenore
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9431 Farmer Dr., Highland, Indiana 46322
20c. Relationship: Son

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 4, 1995 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Dean G. Wagner
22b. EMBALMER'S LICENSE NO.: 8800057
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Dean G. Wagner
24b. LICENSE NUMBER (of Licensee): 8800057
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Solan Funeral Home FH83002893 7109 Calumet Ave., Hammond, In. 46324

CAUSE OF DEATH

26. PART I. Enter the diseases, 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Metastatic carcinoma of the colon — Approximate Interval Between Onset and Death: 1 yr
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: [signature]
29c. MEDICAL LICENSE NO.: 01036239
29d. DATE SIGNED (Month, Day, Year): May 05-02-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. H. Gleaton, M.D., 7905 Calumet Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin ... M.D.
32. DATE FILED (Month, Day, Year): MAY 02 1995

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