



TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

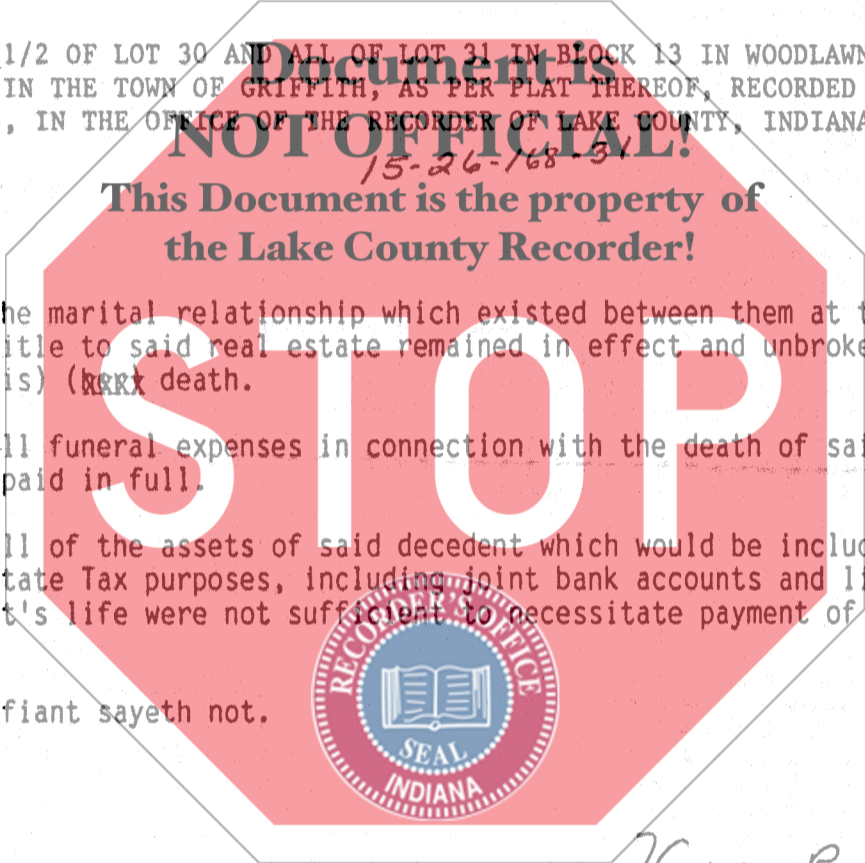
95067597

VERA R. PRICE, being first duly sworn upon oath, deposes and says:

1. That PHILIP E. PRICE died on August 17, 1995 at Griffith, Ind.

2. That VERA R. PRICE and PHILIP E. PRICE were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

THE NORTH 1/2 OF LOT 30 AND ALL OF LOT 31 IN BLOCK 13 IN WOODLAWN ADDITION TO GRIFFITH, IN THE TOWN OF GRIFFITH, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 21 PAGE 15, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 NOV - 6 AM 10: 22
MARGARET M. BELAND
RECORDER

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.

Vera R. Price
VERA R. PRICE

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

FILED

NOV 3 1995

Awilda Galvan
AWILDA GALVAN Notary Public

My Commission expires:
10-18-96 **SAM ORLICH**
AUDITOR LAKE COUNTY

County of Residence:
LAKE

This Instrument prepared by VERA R. PRICE

000282

11.00
7
SW

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1837-95

State No. _____

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Philip Price		2 SEX Male	3a TIME OF DEATH 2:00 P.M.	3b DATE OF DEATH (Month Day Yr) August 17, 1995
4 SOCIAL SECURITY NUMBER 305-09-9629	5a AGE—Last Birthday (Year) 78	5b UNDER 1 YEAR Month Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Aug. 21, 1916
7 BIRTHPLACE (City and State or Foreign Country) Muncie, Indiana	8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	

DECEDENT

9b FACILITY NAME (If not institution give street and number) 145 N. Harvey		9c CITY TOWN OR LOCATION OF DEATH Griffith	9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Vera Wilcox	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Purchase Agent	12b KIND OF BUSINESS/INDUSTRY Screw & Bolt Co.
13a RESIDENCE—STATE Indiana	13b COUNTY lake	13c CITY TOWN OR LOCATION Griffith	13d STREET AND NUMBER 145 N. Harvey
13e ZIP CODE 46319	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (Specify Cuban Mexican Puerto Rican etc.)
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16 RACE—American Indian, Black, White, etc. (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5+)

PARENTS

18 FATHER'S NAME (First Middle Last) Howard Price	19 MOTHER'S NAME (First Middle Maiden Surname) Mabel Van Arsdale
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INFORMANT

20a INFORMANT'S NAME (Type/Print) Vera Price	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 145 N. Harvey Griffith, Indiana	20c Relationship Wife
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DISPOSITION

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) August 19, 1995 Chapel Lawn cemetery	21c LOCATION—City or Town State Schererville, Indiana
22a EMBALMER'S NAME David Peterson	22b EMBALMER'S LICENSE NO. FDO 8601585	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>	24b LICENSE NUMBER (of licensee) FDO 1014511	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500

CAUSE OF DEATH

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)
Long adenocarcinoma of prostate

CONDITIONS if any which gave rise to the immediate cause stating the underlying cause last
Aug 21 1995

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
Alberto R. Sanchez

29c MEDICAL LICENSE NO.
01033214

29d DATE SIGNED (Month Day Year)
8/18/95

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Alberto R. Sanchez, M.D. 2114 45th Ave Highland IN 46022

31 HEALTH OFFICER'S SIGNATURE
William A. Williams, M.D.

32 DATE FILED (Month Day Year)
August 21, 1995

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 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.		