4827707 LD 4047

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
COUNTY OF LAKE } S. S.

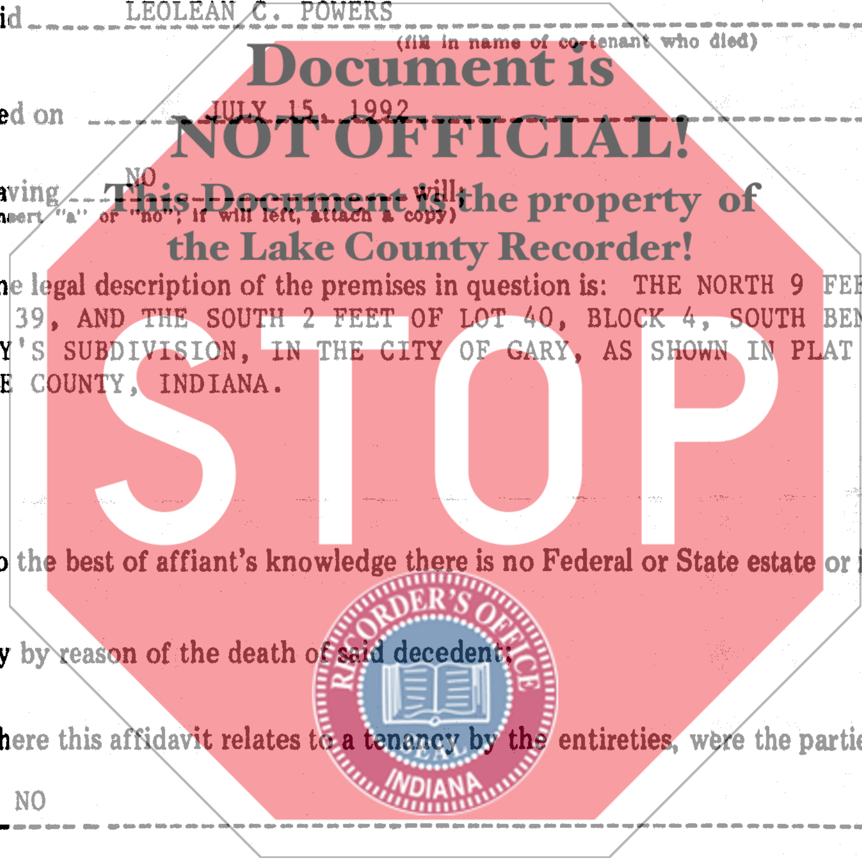
On this 21ST OF NOVEMBER (insert date) before me personally appeared MAMON POWERS SR

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is OWNER (state interest of affiant in the above premises as "owner," "son of owner," etc.);
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by MAMON POWERS and LEOLEAN C. POWERS;
4. Said LEOLEAN C. POWERS (fill in name of co-tenant who died)

   died on JULY 15, 1992

   leaving NO will. (insert "a" or "no"; if will left, attach a copy)



5. The legal description of the premises in question is: THE NORTH 9 FEET OF LOT 38, ALL OF LOT 39, AND THE SOUTH 2 FEET OF LOT 40, BLOCK 4, SOUTH BEND AND GARY LAND COMPANY'S SUBDIVISION, IN THE CITY OF GARY, AS SHOWN IN PLAT BOOK 8, PAGE 12, IN LAKE COUNTY, INDIANA.
6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent;
7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

   NO

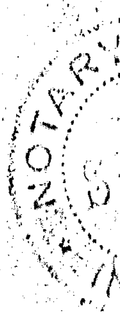
   (If answer is "Yes," identify the divorce proceedings:);
8. Affiant's relationship to the deceased was HUSBAND.

Signature: [signature]

Address: 2077 HARRISON ST. GARY, IN 46407

Subscribed and sworn to before me by the affiant

this 21ST DAY OF NOVEMBER (insert date)



[signature] Notary Public ELIZABETH A. EHLIN

My Commission Expires 9-28-97
RESIDENT OF LAKE COUNTY.

This instrument prepared by MAMON POWERS

95073077

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 NOV 30 PM 1:32
MARGARET CLEVELAND
RECORDER

FILED
NOV 2[illegible] 1995
SAM ORLICH
AUDITOR LAKE COUNTY

Chicago Title Insurance Company

0016[illegible]

8cc

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 92-0483 State No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Leolean C. Powers
2. SEX: Female
3a. TIME OF DEATH: 11:30A M
3b. DATE OF DEATH (Month, Day, Yr): July 15, 1992
4. SOCIAL SECURITY NUMBER: 425-28-6397
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): January 4, 1923
7. BIRTHPLACE (City and State or Foreign Country): Helena, Arkansas
8a. WAS DECEDENT A U.S. VETERAN? NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None
9a. PLACE OF DEATH (Check only one; See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital Northlake
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Mamon Powers Sr.
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Realtor
12b. KIND OF BUSINESS/INDUSTRY: Real Estate
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 2077 Harrison Street
13e. ZIP CODE: 46407
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U S A
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] 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/Secondary (0-12): College (1-4 or 5+): 4 years

PARENTS

18. FATHER'S NAME (First, Middle, Last): Thomas Turner
19. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Fisher

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Mamon Powers Sr.
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2077 Harrison St. Gary, IN 46407
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): July 20, 1992 Evergreen Cemetery
21c. LOCATION—City or Town, State: Hobart, Indiana
22a. EMBALMER'S NAME: Roosevelt Allen Sr.
22b. EMBALMER'S LICENSE NO.: 01051696
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 08700298
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 33007704 Guy & Allen Funeral Directors, Inc 2959 W. 11th Ave Gary, IN 46404

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 Breast — Approximate Interval Between Onset and Death: 19 Months
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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

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): - - - - - - -

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: Barbara L Fuller, M.D.
29c. MEDICAL LICENSE NO.: 01034701
29d. DATE SIGNED (Month, Day, Year): 7/21/92
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Barbara L. Fuller, M.D. 3229 Broadway Gary, In. 46409

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD MPH
32. DATE FILED (Month, Day, Year): JUL 24 1992

CORONER USE ONLY

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?
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.

Oak Park Add Lot 37 Block 12 Key #46-140-37, Unit #25

FILED NOV 29 1995 SAM ORLICH AUDITOR LAKE COUNTY 001673

Chicago Title Insurance Company

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