JOINT TENANCY AFFIDAVIT

STATE OF ILLINOIS }
COUNTY OF Cook } ss.

ORDER NO. COM 199046
DATE: 2-8-96

Carol K. Eriksen f/k/a Carol G. King, hereinafter referred to as the affiant deposes and states that the affiant resides at 3734 W. 215th Street, #301 in the City of Matteson, Illinois:

That the decedent at the time of his/her death was one of the owners of the property in Lake County, ~~Illinois~~ legally described as follows:
Indiana

9601029 4

LOT 177 IN SOUTHTOWN ESTATES 4TH ADDITION TO THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 33, PAGE 3, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

27-300-19

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.

FEB 15 1996

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 FEB 15 AM 9:12
MARGARETTE CLEVELAND
RECORDER

That said decedent died on August 25, 1990 leaving no/a last will and testament;

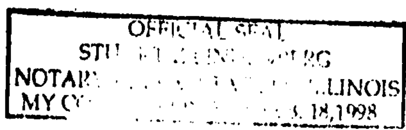
That the total value of the estate of said decedent including his/her taxable interest in the above real estate is $ 125,000.00;

That the Illinois Inheritance Tax and the Federal Estate Tax, if any was due from the decedent's estate, has been paid in full;

That the affiant makes this affidavit to induce TICOR TITLE INSURANCE COMPANY to issue its Policy of Title Insurance on the above described property.

Signature: Carol K. Eriksen
Carol K. Eriksen

SUBSCRIBED AND SWORN TO before me this 8 day of February, 1996
a Notary Public in and for said State and County.



NOTE: If the decedent left a will it will be necessary that the original or a certified copy thereof be presented to us for inspection.

A death certificate together with evidence of payment of death taxes, if any, should accompany this affidavit.

TICOR TITLE INSURANCE
Crown Point, Indiana

000763

Local No. 1757-90

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Ronald W. King
2. SEX: Male
3a. TIME OF DEATH: 1:52 P.M.
3b. DATE OF DEATH (Month, Day, Yr): August 25, 1990
4. SOCIAL SECURITY NUMBER: 331-26-6709
5a. AGE—Last Birthday (Years): 57
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): July 9, 1933
7. BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a. WAS DECEDENT A US VETERAN? Yes
8b. YEAR LAST SERVED IN US ARMED FORCES? 1955
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): 9203 Highland Place
9c. CITY, TOWN, OR LOCATION OF DEATH: Highland
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Carol Harazin
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Retired Supervisor
12b. KIND OF BUSINESS/INDUSTRY: Telephone Co.
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Highland
13d. STREET AND NUMBER: 9203 Highland Place
13e. ZIP CODE: 46322
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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): John King
19. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Wheeler

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Carol King
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9203 Highland Pl. Highland, IN 46322
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 29, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Ronald A. Reed
22b. EMBALMER'S LICENSE NO.: FD01001081
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD0104511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home FDH3007500, 9039 Kleinman Rd. Highland, IN 46322

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Small Cell Lung	
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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

AUG 27 1990

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? No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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.: 01031484
29d. DATE SIGNED (Month, Day, Year): 8-27-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Ray E Draega 8127 Merrillville Rd Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): AUG 27, 90

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? (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.

FILED
FEB 15 1996
SAM ORLICH
AUDITOR LAKE COUNTY
000764

SBH08-004 State Form 10110 (R2/3-89) DFA CERT/PD I