

ESTATE AFFIDAVIT

Key# 6-266-1
Unit 05

RE: FA- 16750

Address: 12413 Alexander Street
Cedar Lake, IN 46303

Legal Description:

LOT 3 IN SHERWOOD PARK, UNIT NO. 1, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 38 PAGE 39, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Cornelia J. Jillson, Affiant, states that:

1. Gerald A. Jillson, deceased, died on the 21st day of October, 1995;

2. Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;

4. The deceased and Affiant were married on the 26th day of Jan., 1957; and were never divorced.
(This item applies only to the surviving spouse.)

5. All expenses of the last illness and funeral of the deceased have been paid;

6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. There are no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

February 13, 1996
Date

Cornelia J. Jillson
Signature of Affiant

Cornelia J. Jillson
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 13th day of February, 1996

Kim A. Diaz
Printed Name of Notary

Kim A. Diaz
Signature of Notary

My Commission expires: 2/15/99

My County of Residence is: LAKE COUNTY

Prepared By: Cornelia J. Jillson

96011174

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 FEB 21 AM 10:58
MARGARET CLINE
RECORDER
DULY ENTERED FOR TRANSFER SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER.

FEB 21 1996

SAM ORLICH
AUDITOR LAKE COUNTY

HOLD FOR FIRST AMERICAN TITLE

1100
20
001088

* 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

FA16750

CERTIFICATE OF DEATH

Local No. 2395-95

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) Gerald A. Jillson		2 SEX Male	3a TIME OF DEATH 9:45 A.M.	3b DATE OF DEATH (Month, Day, Yr.) October 21, 1995
4 SOCIAL SECURITY NUMBER 312-28-7716	5a AGE—Last Birthday (Years) 62	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo., Day, Yr.) Feb. 15, 1933
7 BIRTHPLACE (City and State or Foreign Country) Cedar Lake, Indiana	8a WAS DECEDENT A U.S. VETERAN? YES			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? UNK	8c 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 Southlake Campus		9b CITY, TOWN OR LOCATION OF DEATH Merrillville	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Cornelia Jo Ann Witvliet	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Disabled	12b KIND OF BUSINESS/INDUSTRY Disabled	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Cedar Lake	13d STREET AND NUMBER 12413 Alexander St.	
13e ZIP CODE 46303	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 checked="" type="checkbox"/> No <input type="checkbox"/> 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) 10 College (1-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) John Jillson		
19 MOTHER'S NAME (First, Middle, Maiden Surname) amelia Hein		20a INFORMANT'S NAME (Type/Print) Cornelia J. Jillson		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12413 Alexander St. Cedar Lake, IN		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) October 24, 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>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO 10i4511	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500	
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. Renal failure - congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
26 PART II Enter the conditions contributing to death but not previously stated in Part I. 23 1946				
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)	
29a 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.		29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		29c MEDICAL LICENSE NO. 01028410
29d DATE SIGNED (Month, Day, Year) 10/23/95		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) NAZZAL OBAID, M.D. 8895 Broadway, Merrillville, IN 46410		
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32 DATE FILED (Month, Day, Year) October 23, 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.		34i		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

HOLD FOR FIRST AMERICAN TITLE

FILED
FEB 27 1996
SAM ORLICH
AUDITOR LAKE COUNTY

001089