Lot 8 & N 1/2 Lot 9

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

96066572

UNTY
FILED FOR RECORD

96 OCT -7 AM 11:06

RECORDER

2

AFFIDAVIT FROM A DISINTERESTED PARTY

Date: ~~XXXXXXXX~~ 08/30/96

Case No.: 0 61617

STATE OF INDIANA)
) SS:
COUNTY OF Lake)

William B. Yarvis, Affiant, being duly sworn upon oath, deposes and says:

1. That William Yarvis and Bauhah E. Yarvis were husband and wife at the time they took title to the real estate described herein and that they remained married countinuously until the death of William Yarvis.

LEGAL DESCRIPTION:
Lot 8 and the North ½ of Lot 9, Block 1, Highland Park Addition to Gary, as shown in Plat Book 8, page 13, Lake County, Indiana.

William B. Yarvis
Affiant William B. Yarvis

STATE OF INDIANA)
) SS:
COUNTY OF Lake)

Before me, a Notary Public in and for said County and State, on this 30th day of August, 19 96, personally appeared William B. Yarvis and each acknowleged the execution of the above and foregoing document to be his and/or her voluntary act.

WITNESS my hand and Notarial Seal.

NOTARY PUBLIC Penny Bruno

My commission expires: 08-13-99

Resident of Porter County

This instrument prepared by: William B. Yarvis

FILED

SEP 20 1996

SAM ORLICH
AUDITOR LAKE COUNTY

001213

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11-15

Ltic#61617 LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

STATE OF INDIANA
INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1920-91 State No. ....

1 Orig 2 V.R. 12 Total

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): WILLIAM H. YARVIS
2. SEX: Male
3a. TIME OF DEATH: 3:23P M
3b. DATE OF DEATH (Month, Day, Yr.): September 17, 1991
4. SOCIAL SECURITY NUMBER: 306-09-8106
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr.): JUL 4, 1914
7. BIRTHPLACE (City and State or Foreign Country): CHISHOLM, MINNESOTA
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: WW II
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): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): BEULAH E. SURBER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): ELECTRICIAN
12b. KIND OF BUSINESS/INDUSTRY: US STEEL
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: GARY
13d. STREET AND NUMBER: 4146 JACKSON STREET
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): 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): JOSEPH YARVIS
19. MOTHER'S NAME (First, Middle, Maiden Surname): KATHERINE MIHELICH

INFORMANT

20a. INFORMANT'S NAME (Type/Print): BEULAH E. YARVIS
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4146 JACKSON ST., GARY, IN 46408
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEP 21, 1991 CALVARY CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FDO1004194
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J. Krause
24b. LICENSE NUMBER (of Licensee): FDO1006463
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, IN 46342

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. Ischemic cardiomyopathy (left ventricular failure)
DUE TO (OR AS A CONSEQUENCE OF): b. Coronary artery disease (angina pectoris)
DUE TO (OR AS A CONSEQUENCE OF): Bronchopneumonia
DUE TO (OR AS A CONSEQUENCE OF): Large inguinal hernia (left) Hiatal hernia

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

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JUL 26 1996
LAKE COUNTY HEALTH COMMISSIONER

FILED

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

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.

SEP 20 1996
SAM ORLICH
AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph J. Sala M.D.
29c. MEDICAL LICENSE NO.: 12924
29d. DATE SIGNED (Month, Day, Year): 19 Sept. 91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOSEPH J. SALA MD, 5490 BROADWAY, MERRILLVILLE, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): September 19, 1991

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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.

001212

SBH05-004 State Form 10110 (R2/3-89) DEA CERT/PD I