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TICOR TITLE INSURANCE

2686 Willowcreek Road
Portage, IN 46368

SURVIVORSHIP AFFIDAVIT

DEBORAH A. LUNDY, being first duly sworn upon her oath, deposes and says:

1. That she is the adult daughter of MARY ANN REMALEY and DONALD JACK REMALEY.

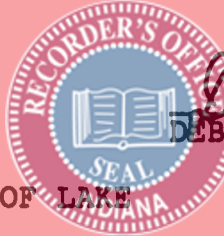
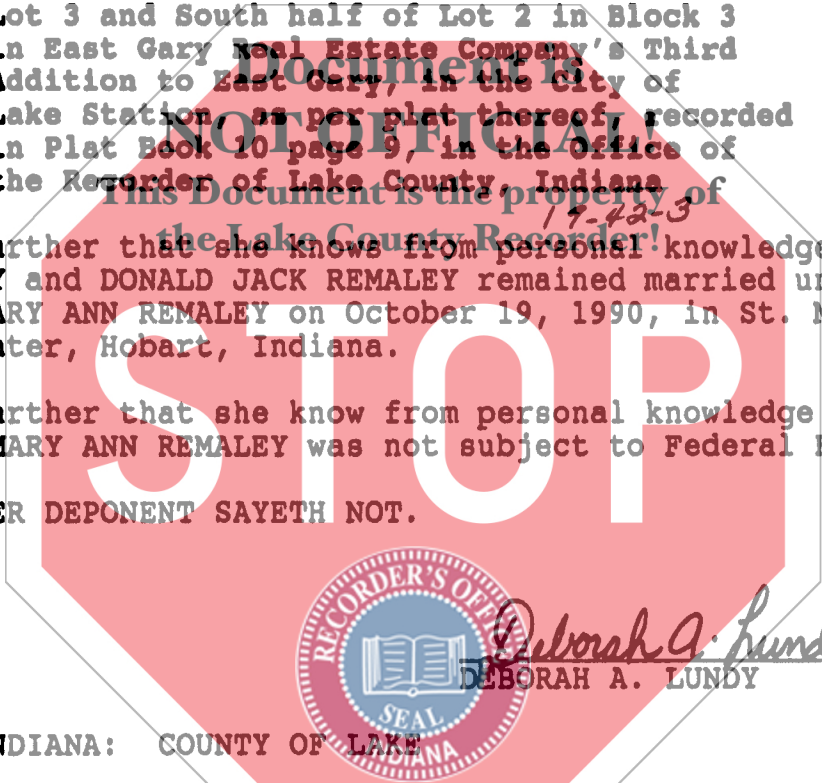
2. That she knows from personal knowledge that MARY ANN REMALEY and DONALD JACK REMALEY were husband and wife at the time they acquired the real estate commonly known as 2206 Vermillion Street, Lake Station, IN, and legally described as:

Lot 3 and South half of Lot 2 in Block 3 in East Gary Real Estate Company's Third Addition to East Gary, in the City of Lake Station, as per plat thereof recorded in Plat Book 10 page 9, in the Office of the Recorder of Lake County, Indiana

3. Further that she knows from personal knowledge that MARY ANN REMALEY and DONALD JACK REMALEY remained married until the death of MARY ANN REMALEY on October 19, 1990, in St. Mary Medical Center, Hobart, Indiana.

4. Further that she know from personal knowledge that the estate of MARY ANN REMALEY was not subject to Federal Estate Tax.

FURTHER DEPONENT SAYETH NOT.



Deborah A. Lundy
DEBORAH A. LUNDY

MARGARETTE CLEVELAND
RECORDER

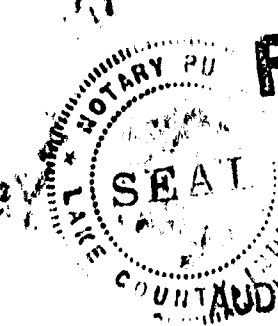
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96 OCT -9 AM 9:50

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA: COUNTY OF LAKE

Subscribed and sworn to before the undersigned Notary Public on October 3, 1996.



FILED

OCT 8 1996

SAM ORLICH
AUDITOR LAKE COUNTY

R. T. Moore
R. T. MOORE, Notary Public
Lake County resident
My commission expires 8/3/00

ATTY ROGER T. MOORE, PC, #9289-64, 6195 Central Avenue, Portage, IN 46368
Telephone (219) 762-0402; Facsimile (219) 762-7525

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INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

File No. 2135-90

State No. 266610.00

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) MARY ANN REMALEY		2. SEX FEMALE	3a. TIME OF DEATH 3:18P	3b. DATE OF DEATH (Month, Day, Yr) OCTOBER 19, 1990	
4. SOCIAL SECURITY NUMBER 305-32-5323	5a. AGE—Last Birthday (Years) 58	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr) OCTOBER 15, 1932	
7. BIRTHPLACE (City and State or Foreign Country) GARY, INDIANA	8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	8c. PLACE OF DEATH (Check only one (See instructions)) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Other (Specify)		
9a. FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER		9b. CITY, TOWN, OR LOCATION OF DEATH HOBART, I		9c. COUNTY OF DEATH LAKE	
10. MARITAL STATUS MARRIED	11. SURVIVING SPOUSE (If not, give maiden name) DONALD REMALEY	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) PROOF READER		12b. KIND OF BUSINESS/INDUSTRY HERALD NEWS GROUP	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION LAKE STATION	13d. STREET AND NUMBER 2206 VERMILLION ST.		
13e. ZIP CODE 46405	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" 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) 10		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
18. FATHER'S NAME (First, Middle, Last) ROBERT MUNRO		18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY BURKE			
20a. INFORMANT'S NAME (Type/Print) DONALD REMALEY		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2206 VERMILLION ST., LAKE STATION, INDIANA, 46405		20c. Relationship HUSBAND	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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 22, 1990 CALVARY CEMETERY		21c. LOCATION—City or Town, State PORTAGE, INDIANA	
22a. EMBALMER'S NAME JAMES W. GROLSTON		22b. EMBALMER'S LICENSE NO. FDO 1004194	22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>David C. Meyer</i>		24b. LICENSE NUMBER (of Licensee) FDO 1012048	24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME REES FUNERAL HOME, OLSON CHAPEL FDH 3003069 5341 CENTRAL AVE., PORTAGE, IN 46368		
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) <i>Small cell lung cancer with brain metastasis</i> DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause stating the underlying cause last PART II. Other significant conditions - Conditions contributing to death but not directly causing it. FILED		THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.			
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	
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>Patricia J. ...</i> LAKE COUNTY HEALTH COMMISSIONER			
29c. MEDICAL LICENSE NO. 01031667		29d. DATE SIGNED (Month, Day, Year) Oct 23, 90			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) PIMPA J. TARA, M.D., 8127 MERRILLVILLE RD., MERRILLVILLE, IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>Patricia J. ...</i>				32. DATE FILED (Month, Day, Year) OCT 23, 90	
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY



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