97035767

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

WINSLOW LEROY STEPHIC, /A/K/A WINSLOW L. STEPHIC being first duly sworn upon oath, deposes and says:

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 97 JUN -5 AM 9:58 MORRIS W. CARTER RECORDER

1. That JUDITH A. STEPHIC died on August 28, 1995 at 2:40 PM

2. That WINSLOW LEROY STEPHIC A/K/A WINSLOW L. STEPHIC and JUDITH A. STEPHIC were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

THE SOUTH 1/2 OF LOT 2 IN BLOCK 13 IN HOBART PARK ADDITION TO HOBART, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 12 PAGE 30, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA. 18-41-15

*see Attached exhibit "A" for copy of certificate.

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.

4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

WINSLOW LEROY STEPHIC, AKA WINSLOW L. STEPHIC

Subscribed and sworn to before me, a Notary Public, this 30TH day of MAY, 19 97.

Notary Public

My Commission expires:

County of Residence:

JACALYN L. SMITH
NOTARY PUBLIC STATE OF INDIANA
Resident of Lake County
My Commission Expires December 8, 1999

000231

This Instrument prepared by Winslow L. Stephic

Ticor - Hobart 805726

ENTION ESTATE: The Social Security # is requested by this state agency in order to its statutory responsibility. Disclosure is ary and there will be no penalty for refusal.

l No. 1913-95 1913-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

E/PRINT IN MANENT CK INK

1 DECEASED—NAME (First Middle Last): JUDITH A. STEPHIC
2 SEX: FEMALE
3a TIME OF DEATH: 2:40 P M
3b DATE OF DEATH (Month Day Yr): AUGUST 28, 1995

4 SOCIAL SECURITY NUMBER: 304-36-8521
5a AGE—Last Birthday (Years): 64
5b UNDER 1 YEAR (Months / Days):
5c UNDER 1 DAY (Hours / Minutes):
6 DATE OF BIRTH (Mo Day Yr): FEB. 21, 1931
7 BIRTHPLACE (City and State or Foreign Country): FRANKFORD, INDIANA

8a WAS DECEDENT A U.S. VETERAN? NO
8b YEAR LAST SERVED IN US ARMED FORCES? NO
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

ENT

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): WINSLOW L. STEPHIC
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): TEACHER-OWNER
12b KIND OF BUSINESS/INDUSTRY: HOBART SCHOOL SYSTEM STEPHIC SCHOOL SUPPLY

13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY TOWN OR LOCATION: HOBART
13d STREET AND NUMBER: 216 S. WASHINGTON

13e ZIP CODE: 46342
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+): 6

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18 FATHER'S NAME (First Middle Last): CARL W. AGNEW
19 MOTHER'S NAME (First Middle Maiden Surname): ELIZABETH KELLEY

MANT

20a INFORMANT'S NAME (Type/Print): WINSLOW L. STEPHIC
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 S. WASHINGTON ST., HOBART, IN. 46342
20c Relationship: HUSBAND

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 30, 1995 NW INDIANA CREMATION SERVICE
21c LOCATION—City or Town, State: CROWN POINT, INDIANA

SITION

22a EMBALMER'S NAME: N/A
22b EMBALMER'S LICENSE NO: N/A
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Gordon L. Jones
24b LICENSE NUMBER (of Licensee): 1010711
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH#83002380 701 E. 7TH STREET, HOBART, INDIANA 46342

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

E OF

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Breast Carcinoma —
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
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):
☒ 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.

IER

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 01037515
29d DATE SIGNED (Month Day Year): 8-29-95

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MILTON S. GASPARIS, M. D., 1400 S. LAKE PARK, SUITE 301, HOBART, INDIANA 46342

31 HEALTH OFFICER'S SIGNATURE: [signature], M.D.
32 DATE FILED (Month Day Year): August 29, 1995

R

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.

THIS IS TO CERTIFY THAT ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HEALTH DEPT. Sep 29 1995 [signature]

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

NTION ESTATE: The Social Security # is requested by this state agency in order to its statutory responsibility. Disclosure is ry and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

No. 19 13-95 1913-95 **CERTIFICATE OF DEATH** State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-16-3

/PRINT
JN
ANENT
CK INK

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
JUDITH A. STEPHIC	FEMALE	2:40 P M	AUGUST 28, 1995

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Mo. Day. Yr)	7 BIRTHPLACE (City and State or Foreign Country)
304-36-8521	64			FEB. 21, 1931	FRANKFORD, INDIANA

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9 PLACE OF DEATH (Check only one. See instructions)
NO	NO	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARY MEDICAL CENTER	HOBART	LAKE

10 MARITAL STATUS (At time of death)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	WINSLOW L. STEPHIC	TEACHER-OWNER	HOBART SCHOOL SYSTEM STEPHIC SCHOOL SUPPLY

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HOBART	216 S. WASHINGTON

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46342	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc)	WHITE	12	6

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
CARL W. AGNEW	ELIZABETH KELLEY

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
WINSLOW L. STEPHIC	216 S. WASHINGTON ST., HOBART, IN. 46342	HUSBAND

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment	AUGUST 30, 1995 NW INDIANA CREMATION SERVICE	CROWN POINT, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
N/A	N/A	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Gordon L. Jones	1010711	BURNS FUNERAL HOME FDH#83002380 701 E. 7TH STREET, HOBART, INDIANA 46342

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 BRAIN CANCER	
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

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

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
M. Gasparis	01037515	8-29-95

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29 (Type/Print)
MILTON S. GASPARIS, M. D., 1400 E. LAKE PARK, SUITE 301, HOBART, INDIANA 46342

31 HEALTH OFFICER'S SIGNATURE Alejandro D. Nolasco, M.D. 32 DATE FILED (Month, Day, Year) August 29, 1995

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1