

TICOR TITLE INSURANCE

97035767

AFFIDAVIT

STATE OF INDIANA )
COUNTY OF LAKE ) SS:

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

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

\* 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.



Signature of Winslow L. Steptic

Subscribed and sworn to before me, a Notary Public, this 30th day of MAY, 1997.

Signature of 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. Steptic

Handwritten initials and date: 11/00

Ticor - Hobart 805726

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
RECORDER
97 JUN -5 AM 9:59

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

INDIANA STATE DEPARTMENT OF HEALTH

No. 19-19-25 1913-95 CERTIFICATE OF DEATH State No. ....

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

PRINT IN PERMANENT INK

IDENT

IDENT

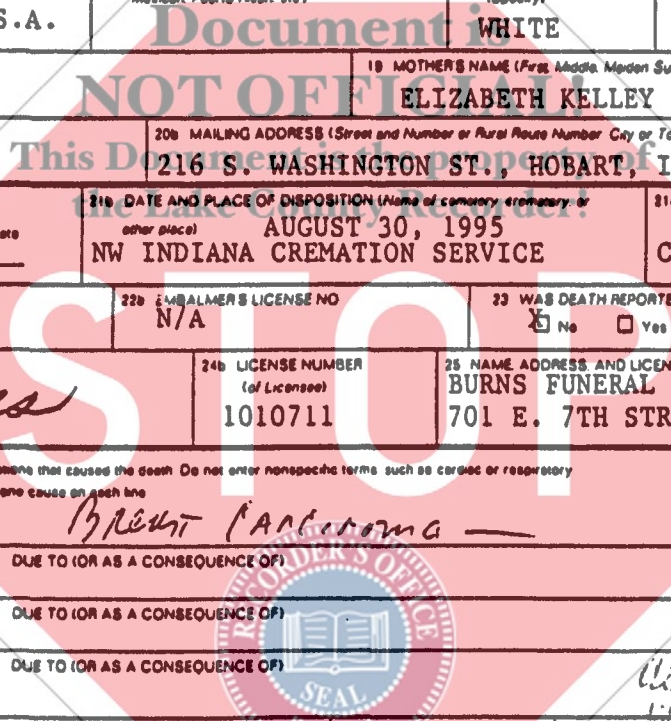
IDENT

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IDENT

1 DECEASED—NAME (First Middle Last) <b>JUDITH A. STEPHIC</b>		2 SEX <b>FEMALE</b>	3a TIME OF DEATH <b>2:40 P M</b>	3b DATE OF DEATH (Month Day Year) <b>AUGUST 28, 1995</b>	
4 SOCIAL SECURITY NUMBER <b>304-36-8521</b>	5a AGE—Last Birthday (Years) <b>64</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>FEB. 21, 1931</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>FRANKFORD, INDIANA</b>	8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>NO</b>		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA 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) <b>ST. MARY MEDICAL CENTER</b>		9b CITY TOWN OR LOCATION OF DEATH <b>HOBART</b>	9c COUNTY OF DEATH <b>LAKE</b>		
10 MARITAL STATUS <b>MARRIED</b>	11 SURVIVING SPOUSE (If not, give last name) <b>WINSLOW L. STEPHIC</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>TEACHER-OWNER</b>		12b KIND OF BUSINESS/INDUSTRY <b>HOBART SCHOOL SYSTEM STEPHIC SCHOOL SUPPLY</b>	
13a RESIDENCE—STATE <b>INDIANA</b>	13b COUNTY <b>LAKE</b>	13c CITY TOWN OR LOCATION <b>HOBART</b>	13d STREET AND NUMBER <b>216 S. WASHINGTON</b>		
13e ZIP CODE <b>46342</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>WHITE</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>6</b>	18 FATHER'S NAME (First Middle Last) <b>CARL W. AGNEW</b>				
18 MOTHER'S NAME (First Middle, Modern Surname) <b>ELIZABETH KELLEY</b>		19 INFORMANT'S NAME (Type/Print) <b>WINSLOW L. STEPHIC</b>			
20a MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>216 S. WASHINGTON ST., HOBART, IN. 46342</b>		20c Relationship <b>HUSBAND</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>AUGUST 30, 1995 NW INDIANA CREMATION SERVICE</b>		21c LOCATION—City or Town, State <b>CROWN POINT, INDIANA</b>	
22a EMBALMER'S NAME <b>N/A</b>	22b EMBALMER'S LICENSE NO. <b>N/A</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24 SIGNATURE OF FUNERAL DIRECTOR <i>Gordon R. Agnew</i>		24b LICENSE NUMBER (of License) <b>1010711</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BURNS FUNERAL HOME FDH#83002380 701 E. 7TH STREET, HOBART, INDIANA 46342</b>		
26 PART I: Enter the disease, 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. <b>BREAST CARCINOMA</b>					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. 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. DUE TO (OR AS A CONSEQUENCE OF)					
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) <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>		
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>R. Guy</i>	29c MEDICAL LICENSE NO. <b>01037515</b>	29d DATE SIGNED (Month Day Year) <b>8-29-95</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) <b>MILTON S. GASPARIS, M. D., 1400 S. LAKE PARK, SUITE 301, HOBART, INDIANA 46342</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Wesley D. Williams, M.D.</i>			32 DATE FILED (Month Day Year) <i>August 29, 1995</i>		
33 MANNER OF DEATH <input 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
34a 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.			



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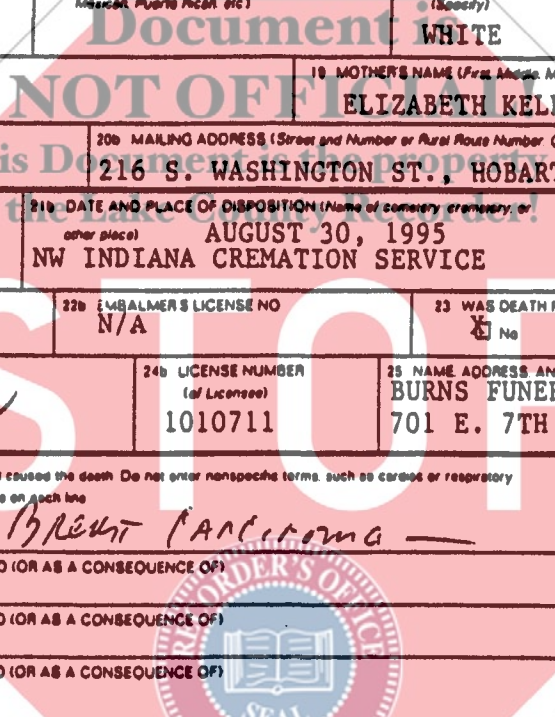
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30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 28) (Type/Print) <b>MILTON S. GASPARIS, M. D., 1400 S. LAKE PARK, SUITE 301, HOBART, INDIANA 46342</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Milton S. Gasparis, M.D.</i>			32 DATE FILED (Month Day Year) <b>August 29, 1995</b>		
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APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OF BREAST CARCINOMA

*Wendell Jones*