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FILED



OCT 03 1997

TICOR TITLE INSURANCE

**SAM ORLICH
AUDITOR LAKE COUNTY**

AFFIDAVIT

97067192

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Etta Vera Webb, being first duly sworn upon oath, deposes and says:

1. That Edward Webb died on April 17, 1993 at Gary, Indiana

2. That Edward Webb and Etta Vera Webb were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

The North 32 feet of Lot 2 and the South 10 feet of Lot 3 in Block [unclear] in Gary Land Company's Fifth Subdivision, in the City of Gary, as per [unclear] thereof, recorded in Plat Book 15 page 3 1/2, in the Office of the Recorder of Lake County, Indiana.

Key No. 44-212-2.

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) (Wife) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. 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.

Etta Vera Webb

Etta Vera Webb

Subscribed and sworn to before me, a Notary Public, this 13th day of August, 1997.

Paula Barrick

Paula Barrick Notary Public

My Commission expires:

10-2-97

County of Residence:

Lake

This Instrument prepared by Etta Vera Webb

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 OCT -6 AM 9:55
MORRIS W. BARTER
RECORDER

000289

12/10/97

INDIANA STATE DEPARTMENT OF HEALTH

Local No. **93-0310**

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1 DECEASED—NAME (First Middle Last) Edward Webb		2 SEX Male	3a TIME OF DEATH 8:14P M	3b DATE OF DEATH (Month Day Year) April 17, 1993	
4 SOCIAL SECURITY NUMBER 315-14-8108	5a AGE—Last Birthday (Years) 69	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) January 4, 1924	
7a WAS DECEDENT A US VETERAN? Yes	7b YEAR LAST SERVED BY US ARMED FORCES? 1947	8a PLACE OF DEATH (Check any one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" 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 Northlake		9b CITY TOWN OR LOCATION OF DEATH Gary	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If not give maiden name) Etta V. Herron	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pump Tender	12b KIND OF BUSINESS/INDUSTRY USX Steel Corp.		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 267 Taft Street		
13e ZIP CODE 46404	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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify) Black	
17 DECEDENT'S EDUCATION (Specify any highest grade completed) Elementary/Secondary (10-12) 12th		18 FATHER'S NAME (First Middle Last) Edward Webb			
19 MOTHER'S NAME (First Middle Maiden surname) Nannie (Unknown)		20a INFORMANT'S NAME (Type/Print) Etta V. Webb			
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 267 Taft Street Gary, Indiana 46404		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) April 22, 1993 Everygreen Cemetery		21c LOCATION—City or Town, State Hobart, Indiana	
22a EMBALMERS NAME Roosevelt Allen Jr.		22b EMBALMERS LICENSE NO. #01051701	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) 08700646	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 83007704 Guy & Allen Funeral Directors, Inc. 2959 W. 11th Avenue Gary, Indiana 46404		
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a <u><i>Hyperbussive cardiovascular disease</i></u> 20/3/93			
b _____		DUE TO (OR AS A CONSEQUENCE OF)			
c _____		DUE TO (OR AS A CONSEQUENCE OF)			
d _____		DUE TO (OR AS A CONSEQUENCE OF)			
26 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
<u><i>Diabetes mellitus</i></u>		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 <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					
29b 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					
29c 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					
29d SIGNATURE AND TITLE OF CERTIFIER 		29e MEDICAL LICENSE NO. 01016849	29f DATE SIGNED (Month Day Year) 4/23/93		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) 3290 GRANT STREET GARY, IN. 46408 DR. H. Bornstein					
31 HEALTH OFFICER'S SIGNATURE 			32 DATE FILED (Month Day Year) APR. 27 1993		
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 (Specify)	34c DESCRIBE HOW INJURY OCCURRED	
34d PLACE OF INJURY—At home farm street factory office building etc (Specify)		34e 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			