

FILED

OCT 14 1997

STATE OF INDIANA)
COUNTY OF LAKE)

SAM ORLICH
AUDITOR LAKE COUNTY

AFFIDAVIT OF SURVIVORSHIP

Comes now Kathryn Price, being duly sworn upon her oath states as follows:

1. That Kathryn Price, is the surviving spouse of Robert Allen Price and the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

1. The S 240' of the W 250' of the NW 1/4 of the SW 1/4 of Section 25 Township 36 North Range 8 W of the 2nd P.M., as per plat thereof, in Lake County, Indiana comprising approximately 1.37 acres, more or less.

Key # 17-35-27

2. Lot 4, Block 1, Sunset Gardens, as shown in Plat Book 26, Page 85, Lake County, Indiana.

Key # 18-225-4

3. The N 1/2 of the SW 1/4 of the SW 1/4 of Section 25, Township 36 North Range 8 West of the 2nd P.M., except the W 300.62' of the N 301.62' thereof, as per plat thereof, in Lake County, Indiana, comprising approximately 17.597 acres more or less.

Key # 17-35-51

2. That Kathryn Price and Robert Allen Price, now deceased, were husband and wife at the time they acquired title; as tenants by the entireties, to said real estate.

3. That the marital relationship which existed between this affiant and Robert Allen Price, remained in effect until the 23rd day of August, 1995, at which time this affiant acquired title to

*Return: Wm. Long
P.O. Box 69
Lake.*

Ticor Title recorded this document as an accommodation. Ticor did not examine the document or the title of the real estate affected.

97070204

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 OCT 16 AM 9:59
MORRIS W. CARTER
RECORDER

2118097-67

TICOR TITLE INSURANCE
Crown Point, Indiana

1310
TE
000753

the Real Estate as surviving tenant by the entireties, said decedent having died testate.

4. That the gross value of the Estate of the Decedent, Robert Allen Price, determined for the purpose of Federal Estate Taxes was neither subject to Federal Estate Tax, nor Indiana Inheritance or Death Taxes.

5. That the purpose of this Affidavit is to establish clear title to said Real Estate and enable the Lake County Auditor to transfer upon its records ownership of said Real Estate in the name of this Affiant for purpose of Taxation.

Further this Affiant sayeth not.

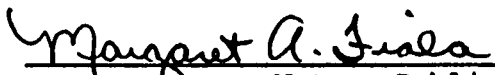

Kathryn Price, Affiant

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, personally appeared Kathryn Price and subscribed and swore on oath to the foregoing Affidavit of Survivorship on this 7th day of October, 1997.

My Commission Expires: 10-12-99

My County of Residence: Lake


Margaret A. Fiala, Notary Public

This Instrument prepared by:

William J. Longer
Atty. No.: 8894-45
651 East Third Street
P. O. Box 69
Hobart, IN 46342
(219) 947-1571

504
218
7304

* ATTENTION ESTATE: Disclosure of the
88 days need to pursue our responsibilities
is voluntary and there will be no penalty for
refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1884-95

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IO 18-1-18-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED NAME (Print Middle Last) ROBERT PRICE, <u>Allen</u>		2. SEX Male	3a. TIME OF DEATH 12:17AM	3b. DATE OF DEATH (Month Day Yr) August 23, 1995
4. SOCIAL SECURITY NUMBER 314-24-0658	5a. AGE - Last Birthday (Years) 66	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Jul 23, 1929
7. BIRTHPLACE (City and State or Foreign Country) Gary, IN	8a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8b. FACILITY NAME (If not institution, give street and number) ST. MARY MEDICAL CENTER	8c. CITY TOWN OR LOCATION OF DEATH Hobart	8d. COUNTY OF DEATH Lake		
9. MARITAL STATUS (Specify) Married	10. SURVIVING SPOUSE (If wife, give maiden name) KATHRYN HOVANEK	11a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) MILLWRIGHT		11b. KIND OF BUSINESS INDUSTRY LOCAL #1043
12a. RESIDENCE - STATE IN	12b. COUNTY Lake	12c. CITY TOWN OR LOCATION Hobart		12d. STREET AND NUMBER 307 N. LIVERPOOL ROAD
13a. ZIP CODE 46342	13b. 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 (Specify) <input type="checkbox"/> Black, White, etc. (Specify) WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (5-12) <input type="checkbox"/> College (1-4 or 5+) 2		18. FATHER'S NAME (Print Middle, Last) WILLIAM E. PRICE		
19. MOTHER'S NAME (Print Middle, Maiden Surname) CORA FAE VANKEN		20a. INFORMANT'S NAME (Type/Print) KATHRYN PRICE		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 N. LIVERPOOL ROAD, Hobart, IN 46342		20c. Relationship Wife		
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) Aug 26, 1995 CALVARY CREMATORY		21c. LOCATION - City or Town State Portage, IN
22a. EMBALMER'S NAME JAMES J. KRAUSE		22b. EMBALMER'S LICENSE NO. FDO1006463		22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
23a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		23b. LICENSE NUMBER (of Licensee) FDO1006463		23c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342
24. COMPLETE COPY OF THIS CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT				
25. IMMEDIATE CAUSE (First disease or condition resulting in death) cardiac arrest AUG 20 1995				
26. DUE TO (OR AS A CONSEQUENCE OF) arteriosclerosis, heart disease				
27. DUE TO (OR AS A CONSEQUENCE OF) post-operative, acute myocardial infarction				
28. PART II Other significant conditions contributing to death but not previously stated in Part I				
27. WAS DECEDENT PREGNANT OR 1-3 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>Donald M. Phillips MD</i>			29c. MEDICAL LICENSE NO. 01020846	29d. DATE SIGNED (Month Day Year) 8/25/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) DONALD M. PHILLIPS MD, 1356 SOUTH LAKE PARK AVE., HOBART, IN 46342				
31. HEALTH OFFICER'S SIGNATURE <i>Donald M. Phillips MD</i>				
32. DATE FILED (Month Day Year) August 25, 1995				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				
34a. TIME OF INJURY (Month Day Year)		34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) 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. No		