

FILED

OCT 17 1997

97071541

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

97 OCT 22 AM 8:42

MORRIS V. CARTER
RECORDER

SAM ORLICH
AUDITOR LAKE COUNTY SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Joseph E. Fraley, being first duly sworn upon oath, deposes and says:

1. That your affiant resides at 3106 Lakeside Drive, Highland, Indiana.

2. That Peggy Ann Fraley died on the 26th day of February, 1995.

3. That your affiant states that the decedent was duly and legally married to Peggy Ann Fraley on the 11th day of November, 1955 and that they acquired title as husband and wife to the following-described real estate located in Lake County, Indiana:

Final Plat Lakeside 13th Add to
Highland All Lots 422 & W. 1/2 of
Lot 421

4. 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 decedent's death.

5. That all funeral expenses, Indiana inheritance taxes and federal estate taxes, if any, in connection with the death of decedent will be determined and paid in full in connection with the estate administration of decedent's estate in the Lake Superior Court, Hammond, Indiana.

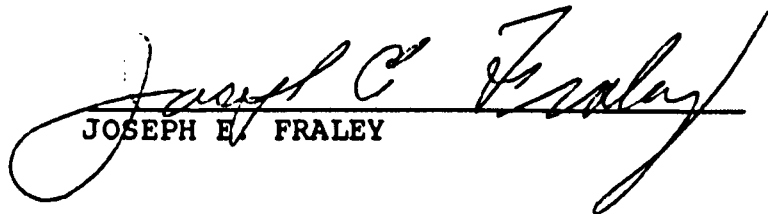
001031

1300
OCT 22 1997
CP

McNee, Myers, McNee, Enslin 53 Muncie Ct - Ind 46320

6. That your affiant makes this Affidavit for purpose of clearing title to the above-described real estate in the names of Joseph E. Fraley and Peggy Ann Fraley.

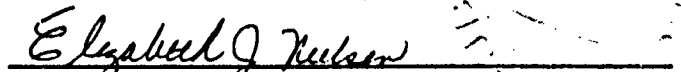
FURTHER, YOUR AFFIANT SAITH NOT.



JOSEPH E. FRALEY

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SUBSCRIBED AND SWORN to before me, a Notary Public in and for said County and State, this 9th day of OCTOBER, 1997.



ELIZABETH J. NIELSEN
NOTARY PUBLIC

My Commission Expires:
3-1-99

County of Residence:
Lake

ATTENTION STATE: Disclosure of the SSN we use to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 171

CERTIFICATE OF DEATH

Feb 28, 1995

Franklin J. O'Connell, M.D. Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Peggy Ann Fraley
2 SEX Female
3a TIME OF DEATH 4:45 P.M.
3b DATE OF DEATH (Month Day Year) February 26, 1995
4 SOCIAL SECURITY NUMBER 313-36-7856
5a AGE—Last Birthday (Year of) 58
5b UNDER 1 YEAR
5c UNDER 1 DAY
6 DATE OF BIRTH (Mo Day Year) Nov. 8, 1937
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)
HOSPITAL [X] Inpatient [] ER/Outpatient [] DOA
OTHER [] Nursing Home [] Other (Specify) [] Residence

DECEDENT

9a FACILITY NAME (If not institution give street and number) St. Margaret Mercy Health Care North
9b CITY/TOWN OR LOCATION OF DEATH Hammond
9c COUNTY OF DEATH Lake

10 MARITAL STATUS (Specify) Married
11 SURVIVING SPOUSE (If wife give maiden name) Joseph Fraley
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Home Maker
12b KIND OF BUSINESS/INDUSTRY Own Home

13a RESIDENCE—STATE Indiana
13b COUNTY Lake
13c CITY/TOWN OR LOCATION Highland
13d STREET AND NUMBER 3106 Lake Side Dr.

13e ZIP CODE 46322
13f INSIDE CITY LIMITS [] No [X] Yes
13g ON A FARM? [X] 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 (10-12) College (1-4 or 5+) 12

PARENTS

18 FATHER'S NAME (First Middle Last) Howard F. Snape
19 MOTHER'S NAME (First Middle Maiden Surname) Ruth Peggy Miller

INFORMANT

20a INFORMANT'S NAME (Type/Print) Joseph Fraley
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Lake Side Dr. Highland, Indiana
20c Relationship Husband

DISPOSITION

21a METHOD OF DISPOSITION [] Entombment [X] Burial [] Cremation [] Removal from State [] Donation [] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) March 2, 1995 Chesterton Cemetery
21c LOCATION—City or Town, State Chesterton, Indiana

22a EMBALMERS NAME Ronald A. Reed
22b EMBALMERS LICENSE NO FDO 1001081
23 WAS DEATH REPORTED TO CORONER? [X] No [] Yes

24a SIGNATURE OF FUNERAL DIRECTOR [Signature]
24b LICENSE NUMBER (of Licensee) FDO 1014511
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FH83007500

CAUSE OF DEATH

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.
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Breast Cancer
DUE TO (OR AS A CONSEQUENCE OF) b. Metastasis multiple
Conditions if any which gave rise to the immediate cause stating the underlying cause last c. 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) 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

CERTIFIER

29a CERTIFIER (Check only one) [X] 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.

HEALTH OFFICER

29b SIGNATURE AND TITLE OF CERTIFIER [Signature]
29c MEDICAL LICENSE NO 01031327
29d DATE SIGNED (Month, Day, Year) Feb 2/28/95

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. P.V. KALOKHE M.D. 8427 KENNEDY AVE. HIGHLAND, IND 46322

31 HEALTH OFFICER'S SIGNATURE [Signature]
32 DATE FILED (Month, Day, Year) February 28, 1995

33 MANNER OF DEATH [] Natural [] Pending Investigation [] Accident [] Suicide [] Homicide [] 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.