FA # TS4162

FILED

LEGAL DESCRIPTION: OCT 22 1997

SAM ORLICH
AUDITOR LAKE COUNTY

RECEIVED
OCT 17 1997
CREDIT UNION MORTGAGE SERVICES, INC.

First American Title Insurance Company

PROPERTY ADDRESS: 1542 Roosevelt St., Gary, IN 46404

97071847

ESTATE AFFIDAVIT

SHIRLEY ANN BAITY, Affiant, states that:

1. EDDIE CLARK, deceased, died on the 7TH day of OCTOBER, 19 93;

2. Affiant is: X the surviving ~~spouse~~ Daughter of the deceased,

   ___ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ___ leaving a will which has been probated;

   ___ leaving a will which has not been probated;

   X leaving no will;

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 OCT 22 AM 10: 23
MORRIS W. CARTER
RECORDER

4. The deceased and Affiant were married on the ___ day of ___, 19 ___; and were never divorced. (This item applies only to the surviving spouse.)

5. X All expenses of the last illness and funeral of the deceased have been paid;

6. X All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

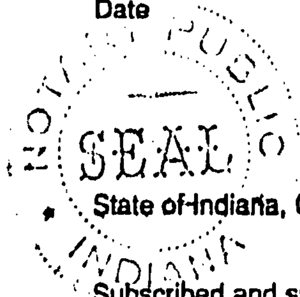
7. X There are no claims against the estate of the decendent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

8-25-97
Date

Shirley A. Baity
Signature of Affiant

SHIRLEY ANN BAITY
Printed Name of Affiant



State of Indiana, County of Lake

Subscribed and sworn to before me, this 25th day of August, 1997.

PATRICIA HOLMAN
Printed Name of Notary

Patricia Holman
Signature of Notary

My Commission expires: 10-13-99

001307

My County of Residence is: Porter

HOLD FOR FIRST AMERICAN TITLE

THIS INSTRUMENT WAS PREPARED BY: V. Cantrell

TRUE COPY OF RECORD OF REGISTRATION ON FILE AT LA PORTE COUNTY HEALTH DEPARTMENT.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. MC398 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. Deceased—Name (First, Middle, Last): Eddie Clark
- 2. Sex: Male
- 3a. Time of Death: 11:21 P.M.
- 3b. Date of Death (Month, Day, Yr): October 7, 1993
- 4. Social Security Number: 428-42-3709
- 5a. Age—Last Birthday (Years): 71
- 5b. Under 1 Year (Months, Days):
- 5c. Under 1 Day (Hours, Minutes):
- 6. Date of Birth (Mo, Day, Yr): March 4, 1922
- 7. Birthplace (City and State or Foreign Country): Carter, Mississippi
- 8a. Was Decedent a US Veteran?: Yes
- 8b. Year Last Served in US Armed Forces: 1943
- 9a. Place of Death (Check only one): Hospital: [X] Inpatient [ ] ER/Outpatient [ ] DOA; Other: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
- 9b. Facility Name (If not institution, give street and number): St. Anthony Hospital
- 9c. City, Town or Location of Death: Michigan City
- 9d. County of Death: LaPorte
- 10. Marital Status (Specify): Married
- 11. Surviving Spouse (If wife, give maiden name): Florida Louise Dotson
- 12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired): Hooker
- 12b. Kind of Business/Industry: Rockwell International
- 13a. Residence—State: Indiana
- 13b. County: Lake
- 13c. City, Town or Location: Gary
- 13d. Street and Number: 1069 Clinton Street
- 13e. Zip Code: 46406
- 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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): [X] No [ ] Yes
- 16. Race—American Indian, Black, White, etc. (Specify): Afro Amer
- 17. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

- 18. Father's Name (First, Middle, Last): Granison Clark
- 19. Mother's Name (First, Middle, Maiden Surname): Dinah Holmes

INFORMANT

- 20a. Informant's Name (Type/Print): Florida L. Clark
- 20b. Mailing Address: 1069 Clinton St., Gary, Indiana 46406
- 20c. Relationship: Wife

DISPOSITION

- 21a. Method of Disposition: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
- 21b. Date and Place of Disposition: October 15, 1993, Evergreen Memorial Park
- 21c. Location—City or Town, State: Hobart, Indiana
- 22a. Embalmer's Name: Sherman G. Banks III
- 22b. Embalmer's License No: FD01016254
- 23. Was Death Reported to Coroner?: [X] No [ ] Yes
- 24a. Signature of Funeral Director: Paula L. Warner
- 24b. License Number (of Licensee): FD09100591
- 25. Name, Address and License Number of Funeral Home: FH89900011, Smith Bizzell Warner & Son, 4209 Grant St., Gary, IN 46408

CAUSE OF DEATH

- 26. Part I. Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, 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. Acute myocardial infarction
  - Due to (or as a consequence of): b.
  - Due to (or as a consequence of): c.
  - Due to (or as a consequence of): d.
  - Approximate Interval Between Onset and Death:
- Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 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.
- 29b. Signature and Title of Certifier: [signature]
- 29c. Medical License No: 20704
- 29d. Date Signed (Month, Day, Year): 10/12/93
- 30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Dr. F.J. Battle, M.D. 1715 Buffalo Street Michigan City, Indiana 46360

HEALTH OFFICER

- 31. Health Officer's Signature: K Aggarwal MD
- 32. Date Filed (Month, Day, Year): 10-12-93

CORONER USE ONLY

- 33. Manner of Death: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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.:

ISSUED OCT 12 1993

SDH06-004 State Form 10110 (R/1-92) DEATHCERT/PO1