

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
SURVIVORSHIP AFFIDAVIT
97 OCT 31 PM 12:22

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97074312

COMES NOW the affiant, JACK W. LEADINGHOUSE, who being first sworn and upon his/her oath and under the penalties for perjury, solemnly swears and states that:

1. He/she is the legal title owner of the real estate located at 5539 SOHL AVENUE HAMMOND, INDIANA 46320, more particularly described as follows, to-wit:
SEE APPENDIX A

2. He/she acquired title to the afore-mentioned real estate with his/her husband/wife by Warranty Deed dated N/A, and recorded N/A, Instrument No. N/A, in the Office of the Recorder of LAKE County, Indiana.

3. He/she and his/hen ~~husband~~ wife, VERNICE LEADINGHOUSE, held title by the entireties until the date of ~~his~~/her death on SEPTEMBER 8, 1995.

4. By virtue of the operation of law in the he/she is the survivor of them, the affiant should now be shown as the sole owner of the real estate.

5. The total value of my late husband's/wife's estate, including the proceeds of life insurance, and interests in jointly owned real estate, was not large enough to be subject to federal estate tax.

Affiant makes these statements to induce the appropriate governmental authorities to cause the title to the real estate to be shown in the sole name of the affiant and that all tax records be shown accordingly.

10/29/97
Date

Jack W. Leadinghouse
(Print Name)
JACK W. LEADINGHOUSE

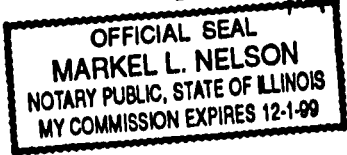
STATE OF ~~INDIANA~~)
ILLINOIS) SS:
COUNTY OF COOK)

SAM ORLICH
AUDITOR LAKE COUNTY

Before me, a Notary Public, in and for said State and County, JACK W. LEADINGHOUSE appeared the affiant herein, who acknowledged the truthfulness of the contents herein.

Done this 28th day of OCTOBER, 1997.

My Commission Expires: 12-1-99.



Markel L. Nelson
Notary Public
Resident of COOK County

Prepared by: AMES HOME LOAN 1000 EAST 80th PLACE, #537
MERRILLVILLE, INDIANA 46410

001939 1400
14641

APPENDIX A

THE SOUTH 1/2 OF LOT 16 AND ALL OF LOT 17 IN BLOCK 1 IN
H.W. SOHL'S 4TH ADDITION TO THE CITY OF HAMMOND, AS PER PLAT
THEREOF, RECORDED IN PLAT BOOK 2, PAGE 5 IN THE OFFICE OF THE
RECORDER OF LAKE COUNTY, INDIANA.

ATTENTION STATE: Disclosure of the
So we need to pursue our responsibilities
voluntary and there will be no penalty for
Mistake.

INDIAN STATE DEPARTMENT OF HEALTH

COMPLETE COPY OF DEATH ON FILE WITH THE
HAMMOND HEALTH DEPARTMENT.

Local No. 657

CERTIFICATE OF DEATH

Signed 12, 1995
Date Issued [Signature] [Signature]
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (First, Middle, Last) Vernice G. Leadinghouse		2. SEX Female	3a. TIME OF DEATH 11:10A.	3b. DATE OF DEATH (Month, Day, Year) September 8, 1995	
4. SOCIAL SECURITY NUMBER 339-32-2716	5a. AGE—Last Birthday (Year) 54	5b. UNDER 1 YEAR Months: Days	5c. UNDER 1 DAY Hours: Minutes	6. DATE OF BIRTH (Month, Day, Year) April 7, 1941	
7. BIRTHPLACE (City and State or Foreign Country) Jasper, AL	8. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DCA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)				
9a. FACILITY NAME (If not available, give street and number) 5539 Sohl St.	9b. CITY, TOWN OR LOCATION OF DEATH Hammond	9c. COUNTY OF DEATH Lake			
10. MARRITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Jack Leadinghouse	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use a remark) Homemaker	12b. KIND OF BUSINESS/INDUSTRY Home		
13a. RESIDENCE—STATE IN	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond	13d. STREET AND NUMBER 5539 Sohl		
13e. ZIP CODE 46320	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) --		18. FATHER'S NAME (First, Middle, Last) Wilburn Smith			
19. MOTHER'S NAME (First, Middle, Last) Inez Harbin		20. INFORMANT'S NAME (Type/print) Jack Leadinghouse			
21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5539 Sohl St. Hammond, IN 46320		22. Relationship Husband			
23. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		24. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) September 12, 1995 Elmwood Cemetery		25. LOCATION—City or Town, State Hammond, IN	
26. EMBALMER'S NAME James Porras		27. EMBALMER'S LICENSE NO. 1045964	28. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
29. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		30. LICENSE NUMBER (of License) 1021590	31. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3002819 5840 Hohman Hammond, IN 46320		
32. 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) Metastatic Invasive Adenocarcinoma DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE, STATING THE UNDERLYING CAUSE LAST DUE TO (OR AS A CONSEQUENCE OF) PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I					
33. 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.		34. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			
35. MEDICAL LICENSE NO. 27970		36. DATE SIGNED (Month, Day, Year) Sept. 11, 1995			
37. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type/print) S. Gailani, M.D. 9116 Columbia Ave. Munster, IN 46321					
38. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		39. DATE FILED (Month, Day, Year) SEP 12 1995			
40. 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"/> Sudden <input type="checkbox"/> Could not be Determined		41. DATE OF INJURY (Month, Day, Year)	42. TIME OF INJURY	43. INJURY AT WORK? (Yes or no)	44. DESCRIBE HOW INJURY OCCURRED
45. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		46. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
47. DATE PRONOUNCED DEAD (Month, Day, Year)		48. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			