Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

8

STATE OF INDIANA
COUNTY OF LAKE } S. S.

On this NOVEMBER 17, 1997 (insert date) before me personally appeared MARY A. TIMMONS

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;

2. Affiant is OWNER (state interest of affiant in the above premises as "owner," "son of owner," etc.);

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by JAMES L. TIMMONS and MARY A. TIMMONS;

4. Said JAMES L. TIMMONS (fill in name of co-tenant who died)
died on APRIL 7, 1997
leaving NO will;
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:

LOT 5, STAFFORD AND TRANKLE'S 6th ADDITION TO HAMMOND, AS SHOWN IN PLAT BOOK 6, PAGE 32, IN LAKE COUNTY, INDIANA.

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent:

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?
NO

(If answer is "Yes," identify the divorce proceedings:
);

8. Affiant's relationship to the deceased was SPOUSE

Signature: Mary A. Timmons
MARY A. TIMMONS
Address: 914 150th ST.
HAMMOND, IN. 46327

Subscribed and sworn to before me by the affiant
this NOVEMBER 17, 1997 (insert date)

Kathy M. Kukula
Notary Public KATHY M. KUKULA, RESIDENT OF LAKE COUNTY

My Commission Expires 11-27-01

This instrument prepared by FRANK X. BECERRA

97081438

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC -1 AM 10:08
MORRIS W. CARTER
RECORDER

FILED
NOV 26 1997
SAM ORLICH
AUDITOR LAKE COUNTY

M-63804

001688 12.00 CT AH

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 272

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

APR 9 1997 Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	James L. Timmons
2 SEX	Male
3a TIME OF DEATH	2:24P M
3b DATE OF DEATH (Month Day Yr)	April 7, 1997
4 SOCIAL SECURITY NUMBER	404-58-2589
5a AGE—Last Birthday (Years)	54
5b UNDER 1 YEAR (Months Days)	
5c UNDER 1 DAY (Hours Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	October 15, 1942
7 BIRTHPLACE (City and State or Foreign Country)	Hardian, Kentucky
8a WAS DECEDENT A US VETERAN?	Yes
8b YEAR LAST SERVED IN US ARMED FORCES?	N.A.
9a PLACE OF DEATH (Check only one See instructions)	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b FACILITY NAME (If not institution give street and number)	St. Margaret Hospital
9c CITY, TOWN OR LOCATION OF DEATH	Hammond
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife give maiden name)	Mary Ann Palasio
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	Laborer
12b KIND OF BUSINESS/INDUSTRY	Construction
13a RESIDENCE—STATE	IN
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Hammond
13d STREET AND NUMBER	914 - 150th St.
13e ZIP CODE	46327
13f INSIDE CITY LIMITS	[ ] No [X] Yes
13g ON A FARM?	[X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?	USA
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)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	8
College (1-4 or 5+)	-------

PARENTS

Field	Entry
18 FATHER'S NAME (First Middle Last)	Kenneth Timmons
19 MOTHER'S NAME (First Middle Maiden Surname)	Lorraine N.A.

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Mary Ann Timmons
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	914 - 150th St Hammond, IN
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	April 10, 1997 Elmwood Cemetery
21c LOCATION—City or Town, State	Hammond, IN
22a EMBALMER'S NAME	James Porras
22b EMBALMER'S LICENSE NO	1045964
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	[signature]
24b LICENSE NUMBER (of Licensee)	8601763
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	Burns-Kish FH 5840 Hohman Ave Hammond IN #3002819

CAUSE OF DEATH

26 PART I Enter the diseases, 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. Carcinoma of Lungs
DUE TO (OR AS A CONSEQUENCE OF)
b. Extensive Bilateral Pneumonia.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions if any which gave rise to the immediate cause stating the underlying cause last

Field	Entry
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)	N.A.

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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	[signature]
29c MEDICAL LICENSE NO	01042343
29d DATE SIGNED (Month Day Year)	April 4-8-97
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. S. Patel, M.D. 5500 Hohman Ave, Hammond, Indiana 46321

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	[signature] M.D.
32 DATE FILED (Month Day Year)	APR 08 1997

Field	Entry
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)	

FILED
NOV 26 1997
SAM ORLICH
AUDITOR LAKE COUNTY
001689