ESTATE AFFIDAVIT

FA- 22029

Address: 8236 TAFT STREET
MERRILLVILLE, IN

HOLD FOR FIRST AMERICAN TITLE

Legal Description: LOT 11 IN INDEPENDENCE HILL THIRD ADDITION, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 24, PAGE 69, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

970082233

ROBERT D. SHARP, Affiant, states that:

1. SHARON K. SHARP, deceased, died on the 9th day of SEPTEMBER, 1992;

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC -2 AM 11:14
MORRIS W. CARTER
RECORDER

2. Affiant is: ✓ the surviving spouse 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;
   ✓ leaving no will;

FILED
DEC 02 1997
SAM ORLICH
AUDITOR LAKE COUNTY

4. The deceased and Affiant were married on the 25 day of Dec., 1974; and were never divorced. (This item applies only to the surviving spouse.)

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

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

7. Yes 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.

NOVEMBER 21, 1997
Date

Robert D Sharp
Signature of Affiant

ROBERT D. SHARP
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 21st day of NOVEMBER, 1997.

CORINA CASTEL RAMOS
Printed Name of Notary

Signature of Notary

My Commission expires: 5/16/01

My County of Residence is: PORTER

Prepared By: ROBERT D. SHARP

000174

12.00 FA Su

Local No. 1909-92

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	Sharon K. Sharp
2 SEX	Female
3a TIME OF DEATH	5:00 P M
3b DATE OF DEATH (Month Day Yr)	September 9, 1992
4 SOCIAL SECURITY NUMBER	307-52-4901
5a AGE—Last Birthday (Years)	45
5b UNDER 1 YEAR (Months / Days)	
5c UNDER 1 DAY (Hours / Minutes)	
6 DATE OF BIRTH (Mo. Day, Yr)	Oct. 18, 1946
7 BIRTHPLACE (City and State or Foreign Country)	Gary, Indiana
8a WAS DECEDENT A US VETERAN?	NO
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 Anthony Hospital
9c CITY, TOWN, OR LOCATION OF DEATH	Crown Point
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Robert Sharp
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Surgery Supply
12b KIND OF BUSINESS/INDUSTRY	Hospital
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	Merrillville
13d STREET AND NUMBER	8236 Taft
13e ZIP CODE	46410
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)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)	College: 3

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	John Skirpan
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Donna Caldwell

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Robert Sharp
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	8236 Taft Merrillville, Indiana
20c Relationship	Husband

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[ ] Burial [X] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	September 12, 1992 Calumet Park Cemetery
21c LOCATION—City or Town, State	Merrillville, Indiana
22a EMBALMER'S NAME	Raymond White
22b EMBALMER'S LICENSE NO.	fDO 8700086
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 fDH 300-7500

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

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Subarachnoid hemorrhage	2 days
b. DUE TO (OR AS A CONSEQUENCE OF)	Aneurysm	unknown
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: Diabetes mellitus - II

Field	Entry
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)	

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] DO
29c MEDICAL LICENSE NO.	02001065
29d DATE SIGNED (Month, Day, Year)	9.10.92
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	KIRK D. SLIFER DO 297 Franciscan Dr, Suite 107 C.P., IN. 46307

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S Williams
32 DATE FILED (Month, Day, Year)	September 10, 1992

CORONER USE ONLY

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 DEC 0_ 1992 SAM ORLICH AUDITOR LAKE COUNTY

000175

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO 1