

FA# 22381

LEGAL DESCRIPTION: Lot 21, Lincoln Gardens second subdivision, as shown, in Plat Book 35, Page 55, in Lake County, Indiana; and Outlot A, Lincoln Gardens 5th Sub, Merrillville, In. 46410



Key #'s 15-363-21 and 15-372-46

ESTATE AFFIDAVIT

97086300

Maxine L. Parr, Affiant, states that:

1. Thomas Dean Parr, deceased, died on the 12th day of February, 1990;

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;

4. The deceased and Affiant were married on the 4th day of June, 1938; and were never divorced. (This item applies only to the surviving spouse.)

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

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

7. There are no claims against the estate of the decedent.

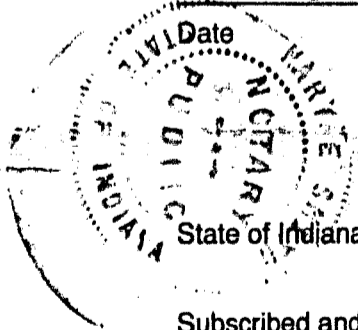
This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC 16 1997
SAM ORLICH
AUDITOR LAKE COUNTY

12-3-97

Maxine L. Parr
Signature of Affiant

MAXINE L. PARR
Printed Name of Affiant



MARY E SMITH
Printed Name of Notary

Mary E Smith
Signature of Notary

My Commission expires: _____
My County of Residence is: _____

HOLD FOR FIRST AMERICAN TITLE

THIS INSTRUMENT WAS PREPARED BY:

Maxine L. Parr

FA 22381 lam
000982

OFFICE of VITAL STATISTICS

CERTIFIED COPY

CERTIFICATE OF DEATH
FLORIDA

LOCAL FILE NO. <u>548</u>		1. DECEDENT'S NAME (First, Middle, Last) <u>Thomas Parr</u> AKA <u>Dean Parr</u>		SEX <u>Male</u>	
DECEDENT	2. DATE OF DEATH (Month, Day, Year) <u>February 12, 1990</u>	4. SOCIAL SECURITY NUMBER <u>307-01-7593</u>		5a. AGE-Last Birthday (years) <u>73</u>	5b. UNDER 1 YEAR Months _____ Days _____
	6. DATE OF BIRTH (Month, Day, Year) <u>October 28, 1916</u>	7. BIRTHPLACE (City and State or Foreign Country) <u>Ashley, Indiana</u>		8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) <u>No</u>	
	9a. PLACE OF DEATH (Check only one: see instructions on other side) <u>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</u>	9b. INSIDE CITY LIMITS? (Yes or No) <u>NO</u>		9c. COUNTY OF DEATH <u>Lee</u>	
46-99	9c. FACILITY NAME (If not institution, give street and number) <u>East Pointe Hospital</u>		9d. CITY, TOWN, OR LOCATION OF DEATH <u>Lehigh Acres</u>		9e. COUNTY OF DEATH <u>Lee</u>
	10. GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE. DO NOT USE RETIRED.	10a. DECEDENT'S USUAL OCCUPATION <u>General Foreman</u>	10b. KIND OF BUSINESS/INDUSTRY <u>Steel</u>	11. MARITAL STATUS — Married, Never Married, Widowed, Divorced (Specify) <u>Married</u>	12. SURVIVING SPOUSE (If wife, give maiden name) <u>Maxine Lillian Prosser</u>
PART I	13a. RESIDENCE — STATE <u>Indiana</u>	13b. COUNTY <u>Lake</u>	13c. CITY, TOWN, OR LOCATION <u>Merrillville</u>		13d. STREET AND NUMBER <u>7819-Taney Place</u>
	13e. INSIDE CITY LIMITS? (Yes or No) <u>Yes</u>	13f. ZIP CODE <u>46410</u>	14. WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN? (Specify No or Yes — If yes, specify Italian, Cuban, Mexican, Puerto Rican, etc.) <u>No</u>	15. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) _____ College (1-4 or 5+) <u>4</u>
	17. FATHER'S NAME (First, Middle, Last) <u>Lloyd E. Parr</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Lelah C. Robinett</u>		
20a	19a. INFORMANT'S NAME (Type/Print) <u>Mrs. Maxine Parr</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7819 Taney Place Merrillville, Indiana 46410</u>		
DISPOSITION	20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>Chapel Lawn Memorial Garden</u>		20c. LOCATION — City or Town, State <u>Schererville, Indiana</u>
	21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH <u>Keith E. Schmidt</u>		21b. LICENSE NUMBER (of Licensee) <u>2531</u>	21c. NAME AND ADDRESS OF FACILITY <u>Stuckert-McFarland-Schmidt Funeral Home 1910 Del Prado Blvd. Cape Coral, FL 33990</u>	
CERTIFIER	22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated. (Signature and Title) <u>Michael F. Arnall, M.D.</u>		23a. 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. (Signature and Title) <u>Michael F. Arnall, M.D.</u>		
	22b. DATE SIGNED (Mo., Day, Yr.)	22c. HOUR OF DEATH	23b. DATE SIGNED (Mo., Day, Yr.) <u>re-signed March 14, 1990</u>	23c. HOUR OF DEATH <u>8:18 P. M.</u>	
	22d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		23d. PRONOUNCED DEAD (Mo., Day, Yr.) <u>February 12, 1990</u>	23e. PRONOUNCED DEAD (hour) <u>8:18 P. M.</u>	
24. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER) (Type or Print) <u>Michael F. Arnall, M.D. 3949 Evans Ave. Fort Myers, FL 33901</u>					
25a. SUBREGISTRAR — SIGNATURE AND DATE			25b. LOCAL REGISTRAR — SIGNATURE <u>Marlow J. Holleman, Reg</u>		25c. DATE REGISTERED <u>Mar 15, 1990</u>
CAUSE OF DEATH BY CERTIFIER	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.				Approximate Interval Between Onset and Death
	IMMEDIATE CAUSE (Final disease or condition resulting in death) <u>Atherosclerotic heart disease</u>				
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.				
	a. _____ DUE TO (OR AS A CONSEQUENCE OF):				
b. _____ DUE TO (OR AS A CONSEQUENCE OF):					
c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			27a. WAS AN AUTOPSY PERFORMED? (Yes or No) <u>yes</u>	27b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) <u>yes</u>	28. CASE REPORTED TO MEDICAL EXAMINER? (Yes or No) <u>YES</u>
32a	29. IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	30a. IF SURGERY IS MENTIONED IN PART I OR II ENTER CONDITION FOR WHICH IT WAS PERFORMED.		30b. DATE OF SURGERY (Mo., Day, Year)	
32f	31. PROBABLE MANNER OF DEATH (Specify) Accident, suicide or homicide; or undetermined.	32a. DATE OF INJURY (Month, Day, Year)	32b. TIME OF INJURY <u>M</u>	32c. INJURY AT WORK? (Yes or No)	32d. DESCRIBE HOW INJURY OCCURRED
	32e. PLACE OF INJURY — At home, farm, street, factory, etc. (Specify)		32f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

HRS Form 512,
Jan. 89 (Obsoletes
Previous Editions)

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

BY:

Mary Lou Holley

MAR. 15 1990

OLIVER H. BOORDE
State Registrar**WARNING:**ANY REPRODUCTION OF THIS DOCUMENT IS PROHIBITED BY LAW. DO NOT ACCEPT
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SEAL OF THE STATE OF FLORIDA ALTERATION OR ERASURE VOIDS THIS CERTIFICATION

HRS FORM 1564A (8-88)

CERTIFICATION OF VITAL RECORD

