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93 JUN -2 1998

(497913 LD)

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

On this May 28, 1998 before me personally appeared _____
(insert date)

Virginia E. Smith

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

- Affiant resides at the address given below affiant's signature;
- Affiant is owner _____;
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

- Said premises were formerly owned as joint tenants or as tenants by the entireties by Morgan and Virginia E. Smith;

- Said Morgan B. Smith _____
(fill in name of co-tenant who died)
died on Dec. 28, 1997

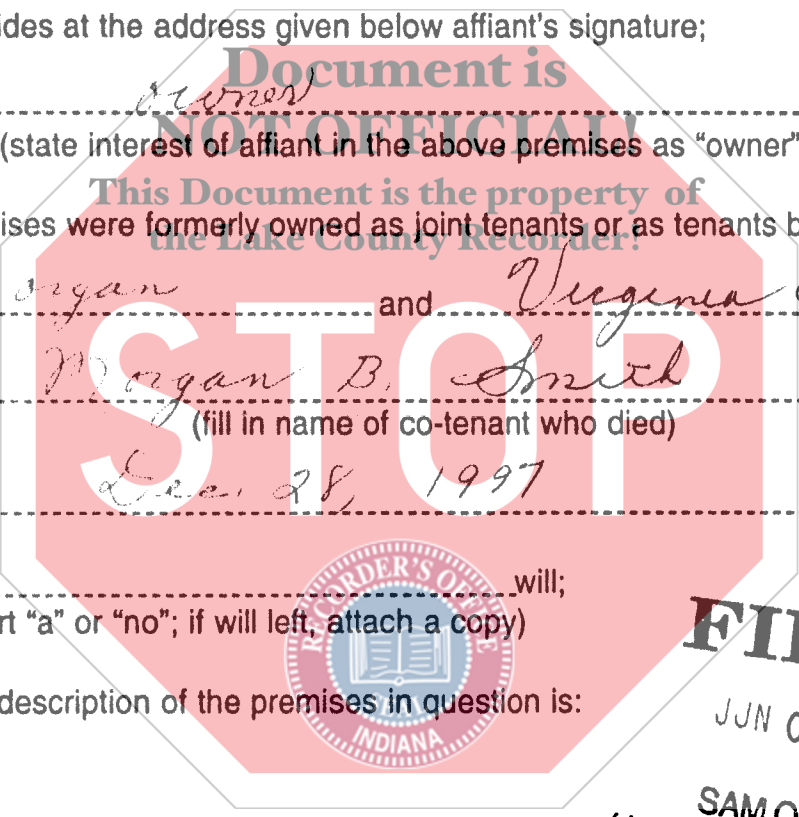
- leaving _____ will;
(insert "a" or "no"; if will left, attach a copy)

- The legal description of the premises in question is:

- Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent? Yes No

If yes, then estimated taxes due are \$ _____

The taxes due are paid or unpaid.



FILED

JUN 02 1998

SAM ORLICH
AUDITOR LAKE COUNTY

Handwritten initials/signature

Chicago Title Insurance Company

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 wife

Signature: Virginia E. Smith

Printed Name VIRGINIA E. SMITH

Address: 7227 Roosevelt Circle
Merrillville, Ind.
46410

Document is NOT OFFICIAL
This Document is the property of
Porter County Recorder!

Subscribed and sworn to before me by the affiant

this May 28th, 1998

(insert date)

Debra Lewis

Notary Public

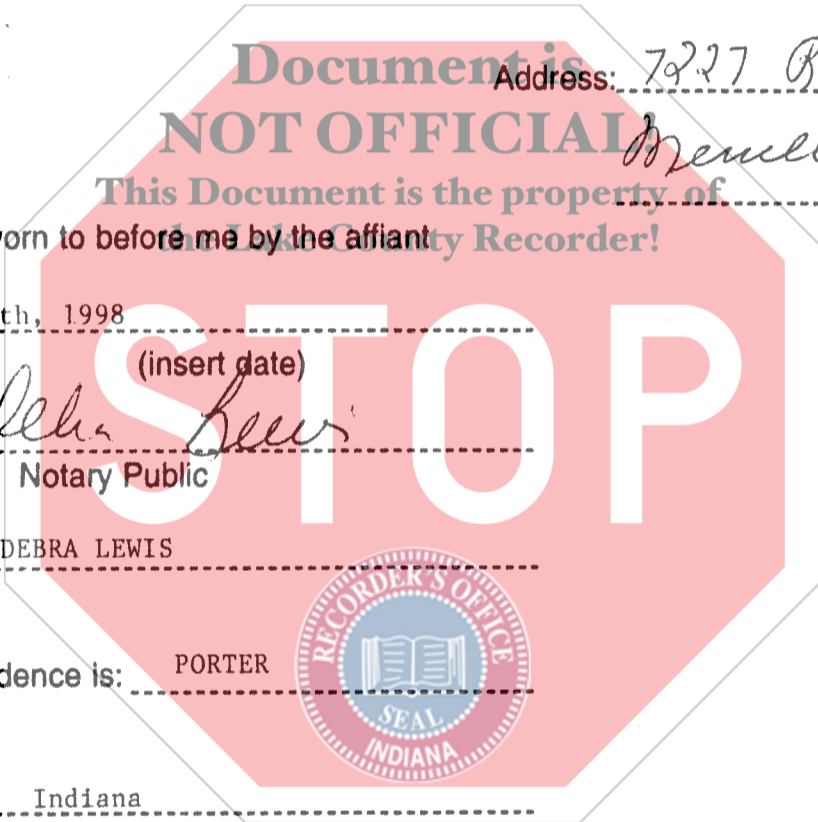
Printed Name DEBRA LEWIS

My County of Residence is: PORTER

In the State of Indiana

My Commission Expires 9-9-98

This instrument prepared by Virginia E. Smith



INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No.

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

OCBL No. 2789-47
 TYPE/PRINT IN PERMANENT BLACK INK
 PRECEDENT
 PARENTS
 INFORMANT
 DISPOSITION
 CAUSE OF DEATH
 CERTIFIER
 HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Morgan Bates Smith Jr.		2 SEX Male	3a TIME OF DEATH 3:08 P	3b DATE OF DEATH (Month Day, Yr) December 28, 1997
4 SOCIAL SECURITY NUMBER 312-14-2428 A		5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day, Yr) February 14, 1920		7 BIRTHPLACE (City and State or Foreign Country) Bridgeport, Ohio		
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	8c PLACE OF DEATH (Check only one box instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake Campus		9b CITY TOWN OR LOCATION OF DEATH Merrillville	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Virginia S. Shepherd	12a DECEDENT'S USUAL OCCUPATION (Give kind of work or profession, occupation, or service, do not use retired) Service Engineer		12b KIND OF BUSINESS/INDUSTRY Typewriter Service
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 6951 Connecticut Street	
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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 (6-12) +2		18 FATHER'S NAME (First Middle Last) Morgan Bates Smith Sr.		
19 MOTHER'S NAME (First Middle Maiden Surname) Zella Doloris Stonecipher		20a INFORMANT'S NAME (Type/Print) Virginia S. Smith		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6951 Connecticut Street Merrillville, IN 46410		20c Relationship Wife		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) January 5, 1998 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, IN
22a EMBALMER'S NAME Robert A. Craig Jr.		22b EMBALMER'S LICENSE NO. FD08700735	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert A. Craig Jr.</i>		24b LICENSE NUMBER (of Licensee) FD08700735	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway Merrillville, IN 46410	
26 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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) b Myocardial I/A DUE TO (OR AS A CONSEQUENCE OF) c Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF) d Diabetes Mellitus poorly				
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? No		28b WAS AN ANATOMY COPY AVAILABLE PRIOR TO CAUSE OF DEATH? (Yes or no) No
29a 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.		29b SIGNATURE AND TITLE OF CERTIFIER <i>R. Hovhannessian M.D.</i>		29c MEDICAL LICENSE NO. 01029583
29d DATE SIGNED (Month, Day, Year) 1/5/98		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) R. Hovhannessian M.D., 7863 Broadway, Merrillville, Indiana 46410 <i>Adelphos A. Hovhannessian, M.D.</i>		
31 DATE FILED (Month, Day, Year) January 11, 1998		32		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d DESCRIBE HOW INJURY OCCURRED CIRCUMSTANCES, TIME, AND PLACE OF OCCURRENCE, AND NAME AND ADDRESS OF HEALTH CARE PROVIDER		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.		000203