98041969

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

LYNDA K. KIRKLAND, being first duly sworn upon oath, deposes and says:

1. That DAN WADE KIRKLAND JR died on OCTOBER 4, 19 96 at LAKE COUNTY INDIANA, Hammond

2. That LYNDA K. KIRKLAND and DAN WADE KIRKLAND JR were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 18, EXCEPT THE NORTH 10 FEET THEREOF, AND LOT 19 IN BLOCK 2 IN WILCOX FIRST ADDITION TO WHITING, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF RECORDED IN ~~PALT~~ Plat BOOK 2 PAGE 51, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

KH 36-346-19

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) ~~(her)~~ death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

FILED JUN 09 [illegible]
SAM ORLICH
AUDITOR LAKE COUNTY

Lynda K Kirkland
LYNDA K. KIRKLAND

Subscribed and sworn to before me, a Notary Public, this 1ST day of JUNE, 19 98.

Sara Superits
SARA SUPERITS
Notary Public

SARA SUPERITS NOTARY Exp. 9-30-2000 PUBLIC LAKE COUNTY, INDIANA

My Commission expires:

9-30-00

County of Residence:

LAKE

This Instrument prepared by LYNDA K/ KIRKLAND

218811 HD

13.00 CM TI

000707

* 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.

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.

Oct. 7, 1996 — Date Issued; [signature] — Hammond Health Commissioner

Local No. 796

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): DAN WADE KIRKLAND JR.
2 SEX: MALE
3a TIME OF DEATH: 3:50 P M
3b DATE OF DEATH (Month Day Yr): OCTOBER 4, 1996
4 *SOCIAL SECURITY NUMBER: 309-46-3656
5a AGE—Last Birthday (Years): 49
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo Day Yr): February 11, 1947
7 BIRTHPLACE (City and State or Foreign Country): COLUMBUS, GEORGIA
8a WAS DECEDENT A U S VETERAN?: YES
8b YEAR LAST SERVED IN US ARMED FORCES?: 1971
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 2742 Birch Avenue
9c CITY, TOWN OR LOCATION OF DEATH: HAMMOND (P.O.Whiting)
9d COUNTY OF DEATH: LAKE
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Lynda Wilson
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Truck Driver
12b KIND OF BUSINESS/INDUSTRY: Trucking
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN OR LOCATION: HAMMOND (P.O.Whiting)
13d STREET AND NUMBER: 2742 Birch Avenue
13e ZIP CODE: 46394
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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 (0-12): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last): Dan Wade Kirkland Sr.
19 MOTHER'S NAME (First Middle Maiden Surname): Katherine Hunt

INFORMANT

20a INFORMANT'S NAME (Type/Print): Lynda Kirkland
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2742 Birch Ave., Whiting, IN 46394
20c Relationship: WIFE

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 7, 1996 Chapel Lawn
21c LOCATION—City or Town, State: Schererville, Indiana
22a EMBALMER'S NAME: THOS. OWENS
22b EMBALMER'S LICENSE NO: FDE 1001049
23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thos Owens [signature]
24b LICENSE NUMBER (of Licensee): FDE 1001049
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: OWENS FUNERAL HOME FDH 3007291 816-119th St., Whiting, IN 46394

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Metastatic lung cancer — Approximate Interval Between Onset and Death: 8 wks
DUE TO (OR AS A CONSEQUENCE OF)
b.
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

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):
☒ 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
29b SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c MEDICAL LICENSE NO: 01040756
29d DATE SIGNED (Month Day Year): 10-7-96
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): G. JANO, M.D., 7905 CALUMET AVE., MUNSTER, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin D. Fernandez MD [signature]
32 DATE FILED (Month Day Year): October 7, 1996

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
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) If yes specify driver, passenger, pedestrian, etc