

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

98045834

98 JUN 18 AM 9:55

MORRIS W. CARTER
RECORDER

Chicago Title Insurance Company

①

H493004 LD

SURVIVORSHIP AFFIDAVIT

On this JUNE 11, 1998 before me personally appeared Cookie M Rowley
(Insert date)

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 Dweller
(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 Thomas A. Rowley and Hazel M. Rowley

4. Said Thomas A. Rowley
(fill in name of co-tenant who died)

died on June 4, 1989

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

5. The legal description of the premises in question is:
LOT 16, EXCEPT THE NORTH 16 FEET THEREOF, ALL OF LOT 17 AND THE NORTH 8 FEET OF LOT 18, BLOCK 1, DOUGLAS PARK MANOR, IN THE CITY OF HAMMOND, AS SHOWN IN PLAT BOOK 17, PAGE 26, IN LAKE COUNTY, INDIANA.

6. 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 17 1998

SAM ORLICH
AUDITOR LAKE COUNTY

13.80
CM
CT

06/04 '98 15:28

001334

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 Spouse

Signature: Cookie M Rowley

Printed Name Cookie M. Rowley

Address: 3835 Sheffield Ave

Hammond In 46327

Subscribed and sworn to before me by the affiant
this 11TH DAY OF JUNE, 1998

(insert date)

Shirley R Kasper
Notary Public

Printed Name

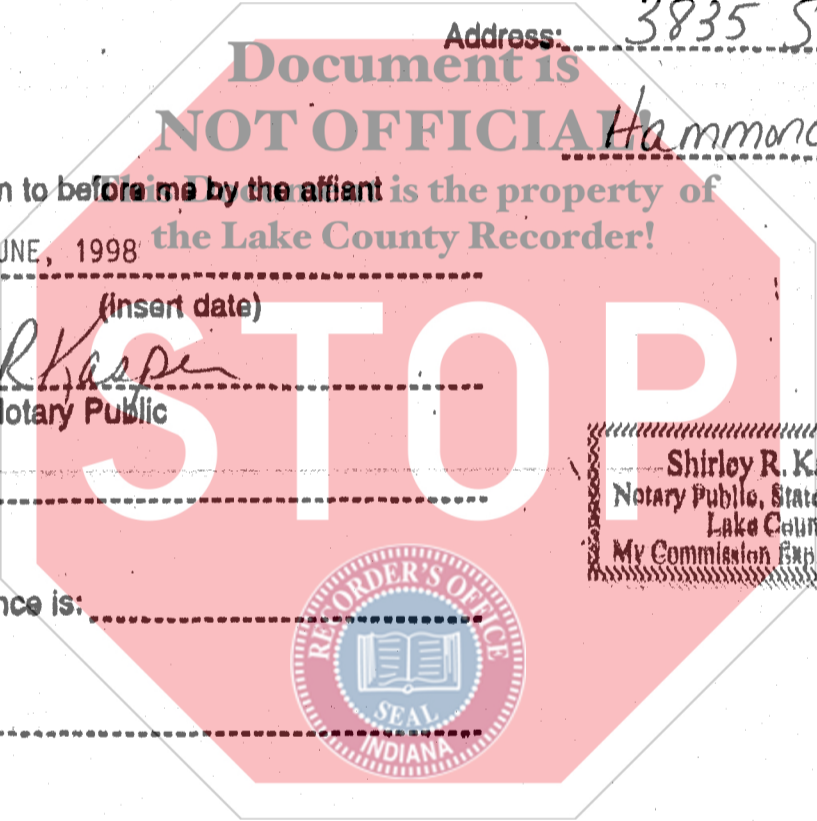
Shirley R. Kasper
Notary Public, State of Indiana
Lake County
My Commission Exp. 07/31/2000

My County of Residence is:

In the State of Indiana

My Commission Expires

This instrument prepared by Cookie M. Rowley



INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

HAMMOND HEALTH DEPARTMENT.

Local No. 425

SU JUN 22 1997
Date Issued
Franklin D. Resnick
Hammond Health Commissioner

TYPE/PRINT
IN
PERMANENT
BLACK INK

INCIDENT

IDENTS

FORMANT

POSITION

ANNOUNCING
/SICIAN ONLY

IS 24 HOURS
COMPLETED BY
PERSON WHO
ANNOUNCED DEATH

INSTRUCTIONS

USE OF
FORM

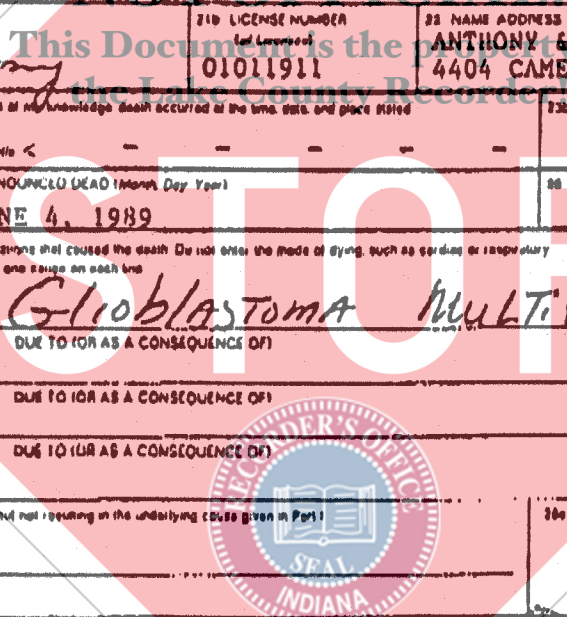
INSTRUCTIONS

IDENTIFIER

LTH
ICER

OWNER OF
SEAL
PERSON USE
ONLY

1 DECEASED - NAME FIRST: THOMAS MIDDLE: A. LAST: ROWLEY		2 SEX MALE	3 DATE OF DEATH (Mo. Day Year) JUNE 4, 1989
4 SOCIAL SECURITY NUMBER 310-52-1412	5a AGE Last Birthday (Year) 43	5b UNDER 1 YEAR Months: Days: Hours: Minutes:	6 DATE OF BIRTH (Month Day Year) MAY 14, 1946
7 YEAR LAST SERVED IN US ARMED FORCES NO	8 PLACE OF BIRTH (City and State or Foreign Country) BERWYN, ILLINOIS		
9 FACILITY NAME (If not applicable give street and number) 3835 SHEFFIELD AVENUE CITY, TOWN, OR LOCATION OF DEATH: HAMMOND COUNTY OF DEATH: LAKE			
10 MARITAL STATUS - Married Never Married Widowed MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) HAZEL COOKIE CLARK	12a DECEASED'S USUAL OCCUPATION (One kind of work done during most of working life) DIE MAKER	12b KIND OF BUSINESS, INDUSTRY STEEL
13a RESIDENCE - STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION HAMMOND	13d STREET AND NUMBER 3835 SHEFFIELD AVENUE
13e INSIDE CITY (YES or NO) YES	13f FARM (YES or NO) NO	13g ZIP CODE 46327	14 WAS DECEASED OF HISPANIC ORIGIN? (Specify No or Yes - If yes specify Cuban, Mexican, Puerto Rican, etc.) No
17 FATHER'S NAME (First Middle Last) WALTER ROWLEY		18 MOTHER'S NAME (First Middle Maiden Surname) NAOMI EGELHOFF	
19a INFORMANT'S NAME (Type/Print) HAZEL COOKIE ROWLEY		19b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 3835 SHEFFIELD, HAMMOND, INDIANA 46327	19c Relationship WIFE
20a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) JUNE 8, 1989 OAKLAND MEMORY LANES	20c LOCATION - City or Town, State DOLTON, ILLINOIS
21a SIGNATURE OF PUBLIC HEALTH DIRECTOR <i>Kurt D. Anderson</i>		21b LICENSE NUMBER 01011911	21c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIEDOWICZ PH - 83002835 4404 CAMERON, HAMMOND, IN 46327
22 Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death		23a To the best of my knowledge death occurred at the time, date, and place listed Signed and Tels	23b LICENSE NUMBER
24 TIME OF DEATH 10:55 AM		25 DATE PRONOUNCED DEAD (Month Day Year) JUNE 4, 1989	26 WAS CASE REFERRED TO MEDICAL EXAMINER, CORONER? (Yes or No) NO
27 PART I - Enter the disease, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Glioblastoma Multiforme DUE TO (OR AS A CONSEQUENCE OF) Secondary to conditions of any leading to immediate cause (Do not UNDERLYING CAUSE (Disease or injury that initiated process resulting in death) LAST			
PART II - Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		28a WAS AN AUTOPSY PERFORMED? (Yes or No) NO	28b WERE FINANCE AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death (See item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <input type="checkbox"/> HEALTH OFFICER On the basis of a coronation and/or investigation, in my opinion, death occurred at the time, date, and place as stated.			
29b SIGNATURE AND TITLE OF CERTIFIER <i>Alan Jones D.O.</i>		29c LICENSE NUMBER MUNSTER LAKE COUNTY	29d DATE SIGNED (Month Day Year) JUNE 5, 1989
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) ALAN JONES D.O. 9428 COLUMBIA AVENUE, MUNSTER, INDIANA 46321			
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Resnick</i>		32 DATE FILED (Month Day Year) JUN 06 1989	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending <input type="checkbox"/> Accidental <input type="checkbox"/> Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined <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	
34e PLACE OF INJURY - At home, farm, school, factory, office, building etc. (Specify)		34f LOCATION (Street and Number of City or Town, State)	



33-14-17