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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

98 JUN 18 AM 9:55

MORRIS W. CARTER
RECORDER

Chicago Title Insurance Company

(1)

H493004 LD

SURVIVORSHIP AFFIDAVIT

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

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 Owner (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

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06/04 '98 15:28

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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

MAY-21-98 03:12 PM P.02

INDIANA STATE BOARD OF HEALTH — CERTIFICATE OF DEATH

HAMMOND HEALTH DEPARTMENT

Local No. 425 — H498004

Date Issued: JUN 20 1989 — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED - NAME	FIRST: THOMAS	MIDDLE: A.	LAST: ROWLEY	2 SEX: MALE	3 DATE OF DEATH: JUNE 4, 1989
4 SOCIAL SECURITY NUMBER: 310-52-1412	5a AGE (Last Birthday): 43	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH: MAY 14, 1946	7 BIRTHPLACE: BERWYN, ILLINOIS
8 YEAR LAST SERVED IN US ARMED FORCES: NO	8a PLACE OF DEATH: HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other				
9a FACILITY NAME: 3835 SHEFFIELD AVENUE	9b CITY, TOWN, OR LOCATION OF DEATH: HAMMOND	9c COUNTY OF DEATH: LAKE			
10 MARITAL STATUS: MARRIED	11 SURVIVING SPOUSE: HAZEL COOKIE CLARK	12a DECEDENT'S USUAL OCCUPATION: 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 LIMITS: YES	13f FARM: NO	13g ZIP CODE: 46327	14 WAS DECEDENT OF HISPANIC ORIGIN: ☒ No ☐ Yes	15 RACE: WHITE	16 DECEDENT'S EDUCATION: Elementary/Secondary (0-12): 12; College (1-4 or 5+):
17 FATHER'S NAME: WALTER ROWLEY	18 MOTHER'S NAME: NAOMI EGELHOFF				
19a INFORMANT'S NAME: HAZEL COOKIE ROWLEY	19b MAILING ADDRESS: 3835 SHEFFIELD, HAMMOND, INDIANA 46327	19c RELATIONSHIP: WIFE			
20a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other	20b DATE AND PLACE OF DISPOSITION: JUNE 8, 1989 OAKLAND MEMORY LANES	20c LOCATION: DOLTON, ILLINOIS			
21a SIGNATURE OF FUNERAL DIRECTOR: Kurt D Anthony	21b LICENSE NUMBER: 01011911	22 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH - 83002835, 4404 CAMERON, HAMMOND, IN 46327			
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 stated. Signature and Title	23b LICENSE NUMBER	23c DATE SIGNED		
24 TIME OF DEATH: 10:55 AM	25 DATE PRONOUNCED DEAD: JUNE 4, 1989	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? NO			

27 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. GLIOBLASTOMA MULTIFORME

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST:

b. DUE TO (OR AS A CONSEQUENCE OF)

c. DUE TO (OR AS A CONSEQUENCE OF)

d. DUE TO (OR AS A CONSEQUENCE OF)

Approximate Interval Between Onset and Death: MONTHS

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 AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

29a CERTIFIER (Check only one)

☒ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23): To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ 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.

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: Alan Jones DO

29c LICENSE NUMBER: SAN OF MICH FOR 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. 9128 COLUMBIA AVENUE, MUNSTER, INDIANA 46321

31 HEALTH OFFICER'S SIGNATURE: Franklin T. Primack M.D.

32 DATE FILED (Month, Day, Year): JUN 06 1989

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 R.F.D. Number, City or Town, State)

#33-14-17

SBH06 004 State Form 10110 Rev 10/87 DEATH/PD1

05/21 '98 15:15