STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

980462 TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

98046062

AFFIDAVIT

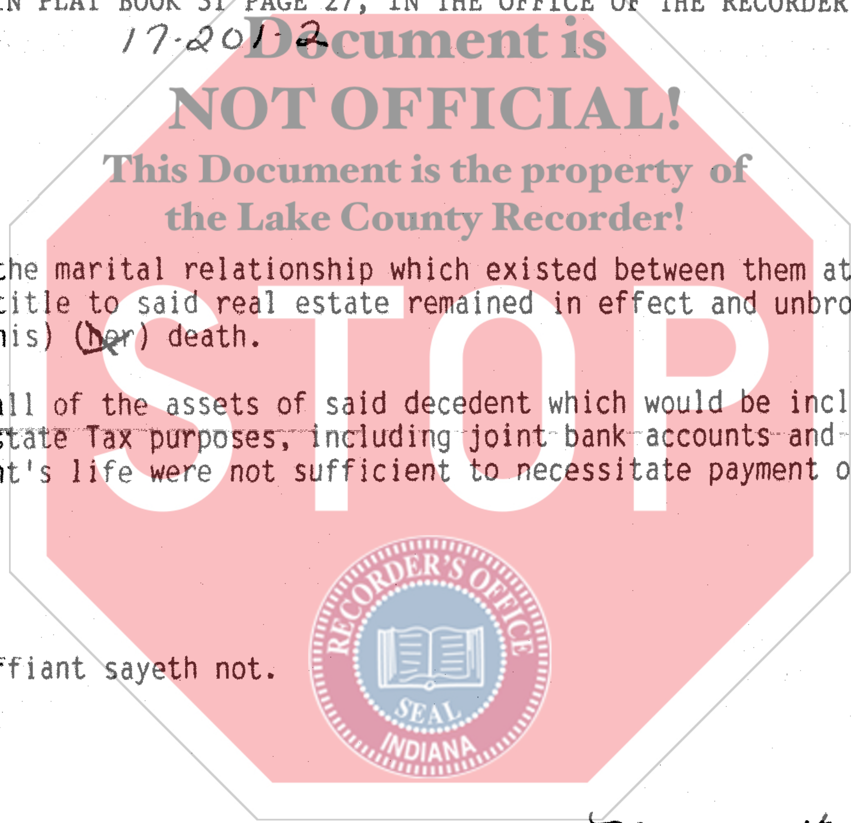
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MARGARET A. MAHONEY, being first duly sworn upon oath, deposes and says:

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
98 JUN 19 AM 9:
MORRIS W. CARTER

1. That JOHN R. MAHONEY died on January 9, 1995 at 6:35 PM.

2. That JOHN R. MAHONEY and MARGARET A. MAHONEY were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
LOT 2, BLOCK 1, FAIRVIEW MANOR FIRST ADDITION TO HOBART, AS PER PLAT THEREOF RECORDED IN PLAT BOOK 31 PAGE 27, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY INDIANA. 17-201-2



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 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.

TICOR TITLE INSURANCE
Crown Point, Indiana
2/9/88

Further affiant sayeth not.

Margaret A Mahoney
MARGARET A. MAHONEY

Subscribed and sworn to before me, a Notary Public, this 16TH day of JUNE, 1998.

[signature]
JACALYN L. JAXSMITH, Notary Public

DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER.
JUN 18 1998
SAM ORLICH
AUDITOR LAKE COUNTY

My Commission expires:
12-08-99

County of Residence:
LAKE

This Instrument prepared by MARGARET A. MAHONEY

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11⁰⁰ Ftn TI

THIS DOCUMENT NOT VALID UNLESS STAMPED ON REVERSE SIDE

PORTER COUNTY BOARD OF HEALTH
MEDICAL CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. Decedent-Name (First Middle Last)	2. Sex	3a. Time of Death	3b. Date of Death (Month Day Yr)
JOHN R. MAHONEY SR.	Male	6:35PM	January 9, 1995

4. Social Security Number	5a. Age - Last Birthday (Years)	5b. Under 1 Year (Months / Days)	5c. Under 1 Day (Hours / Minutes)	6. Date of Birth (Mo Day Yr)	7. Birthplace (City and State or Foreign Country)
317-09-5383	76			May 15, 1918	Gary, IN

8a. Was Decedent a U.S. Veteran?	8b. Year Last Served in U.S. Armed Forces	9a. Place of Death (Check only one. See Instructions)
No	N/A	Hospital: [X] Inpatient [ ] ER/Outpatient [ ] DOA; Other: [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b. Facility Name (If not institution, give street and number)	9c. City Town or Location of Death	9d. County of Death
PORTER MEMORIAL HOSPITAL	Valparaiso	Porter

10. Marital Status (Specify)	11. Surviving Spouse (If wife, give maiden name)	12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)	12b. Kind of Business Industry
Married	MARGARET A. SMITH	OPERATION SUPERVISOR	GARY NATIONAL BANK/GAINER

13a. Residence - State	13b. County	13c. City Town or Location	13d. Street and Number
IN	Lake	Hobart	235 E. 11TH PLACE

13e. Zip Code	13f. Inside City Limits / 13g. On a Farm?	14. Citizen of What Country?	15. Was Decedent of Hispanic Origin? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	16. Race - American Indian, Black, White, etc. (Specify)	17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46342	Inside city limits: [ ] No [X] Yes; On a farm: [X] No [ ] Yes	USA	[X] No [ ] Yes	WHITE	12	

PARENTS

18. Father's Name (First, Middle, Last)	19. Mother's Name (First, Middle, Maiden Surname)
JOHN R. MAHONEY	LOUISE CARNEY

INFORMANT

20a. Informant's Name (Type/Print)	20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
MARGARET A. MAHONEY	235 E. 11TH PLACE, Hobart, IN 46342	Wife

DISPOSITION

21a. Method of Disposition	21b. Date and Place of Disposition (Name of cemetery, crematory or other place)	21c. Location - City or Town State
[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)	Jan 12, 1995 CALUMET PARK CEMETERY	Merrillville, IN

22a. Embalmer's Name	22b. Embalmer's License No.	23. Was Death Reported to Coroner?
JAMES J. KRAUSE	FDO1006463	[X] No [ ] Yes

24a. Signature of Funeral Director	24b. License Number (of Licensee)	25. Name Address and License Number of Funeral Home
James J. Krause	FDO1006463	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF)
b. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF)
c. Myocardial infarction
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)	28a. Was an Autopsy Performed? (Yes or no)	28b. Were Autopsy Findings Available Prior to Completion of Cause of Death? (Yes or no)
	N/A	No	No

CERTIFIER

29a. Certifier (Check only one)
[X] 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	29c. Medical License No	29d. Date Signed (Month Day Year)
James A. Malayter M.D.	01023939	1/11/95

30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print)
JAMES A. MALAYTER MD, 2501 CUMBERLAND DRIVE, Valparaiso, IN 46383

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.

HEALTH OFFICER

31. Health Officer's Signature	32. Date Filed (Month Day Year)
[signature]	January 11, 1995

JUN 18 1998
SAM ORLICH
AUDITOR LAKE COUNTY

33. Manner of Death	34a. Date of Injury (Month Day Year)	34b. Time of Injury	34c. Injury at Work? (Yes or no)	34d. Describe How Injury Occurred
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

34e. Place of Injury - At home, farm, street, factory, 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

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SEAL INDIANA