

STATE OF INDIANA

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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

98 SEP -8 AM 9:01

SS:

MORRIS W. GIBSON
RECORDER

2 COUNTY OF LAKE

AFFIDAVIT OF SURVIVORSHIP

RUTH LANE, being first duly sworn upon
his/her oath, deposes and says:

1. That by Warranty Deed duly recorded 1/7/70,
J P LANE & RUTH LANE acquired title in fee simple
of record to the following described real estate, to wit:

LOTS 19 AND 20 IN BLOCK 1 IN RESUBDIVISION OF GARY LAND COMPANY'S
THIRD SUBDIVISION, IN THE CITY OF GARY, AS PER PLAT OF SAID
RESUBDIVISION, RECORDED IN PLAT BOOK 13, PAGE 8, IN THE OFFICE OF THE
RECORDER OF LAKE COUNTY INDIANA.

2. J P LANE died 1/29/96 and by reason of his/her
death RUTH LANE acquired fee simple title in and to
said real estate, as surviving tenant.

3. The undersigned affiant is informed and verily believes that there are
sufficient assets in the estate of said decedent, separate and apart from the
real estate above described, to fully satisfy discharge any and all liens, taxes
and encumbrances, both federal and state, levied or incurred by reason of
the death of said decedent.

4. This affidavit is made for the purpose of clearing the record title to the
real estate above described.

Ruth Lane
Ruth Lane

Subscribed and sworn to before me this 24TH day of AUGUST, 1998

David E. Woodward
Notary Public David E. Woodward

County of Residence: 08/05/01

My Commission Expires Porter

NOT TO BE USED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER.

SEP 2 1998

SAV. OFFICE
RECORDER LAKE COUNTY

000230

300 E. 90th Pr. Men. 46410
Lucas, Holcomb & Medera

18862
1100
KMC

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its regulatory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

1CC

INDIAN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 96-0066

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) J. P. Lane		2 SEX Male		3a TIME OF DEATH 1:15 A M		3b DATE OF DEATH (Month Day Yr) January 29, 1996	
4 SOCIAL SECURITY NUMBER 721-05-7698		5a AGE—Last Birthday (Years) 68		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo. Day Yr) August 28, 1927		7 BIRTHPLACE (City and State or Foreign Country) Forest City, Arkansas					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Engagement <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake			9c CITY TOWN OR LOCATION OF DEATH Gary		9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Ruth Fuller		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)		12b KIND OF BUSINESS/INDUSTRY USX Steel Corp.	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY TOWN OR LOCATION Gary		13d STREET AND NUMBER 840 Johnson Street	
13e ZIP CODE 46402		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"/> Yes (If yes specify Cuban Mexican Puerto Rican etc.)	
16 RACE—American Indian, Black White etc (Specify) Black		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th					
18 FATHER'S NAME (First Middle Last) Unknown				19 MOTHER'S NAME (First Middle Maiden Surname) Luelle Green			
20a INFORMANT'S NAME (Type/Print) Ruth Lane			20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 840 Johnson Street Gary, Indiana 46402			20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input 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) February 2, 1996 Oak Hill Cemetery			21c LOCATION—City or Town State Gary, Indiana		
22a EMBALMER'S NAME Roosevelt Allen Sr.		22b EMBALMER'S LICENSE NO #01051696		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ruth Lane</i>		24b LICENSE NUMBER (of Licensee) #08700646		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc. 83007704 2959 West 11th Avenue Gary, Indiana 46404			
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions if any, which gave rise to the immediate cause stating the underlying cause last a <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF) b <i>CVA & renal plaque</i> DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) d		Approximate Interval Between Onset and Death <i>Acute</i>		Approximate Interval Between Onset and Death <i>Chronic</i>			
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)			
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>G. G. Badar</i>			29c MEDICAL LICENSE NO 26783		29d DATE SIGNED (Month Day Year) 2-5-96		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. G. Badar 5490 Broadway Merrillville Indiana 46410							
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32 DATE FILED (Month Day Year) FEB 09 1996	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year) SEP 2 1998		34b TIME OF INJURY		34c INJURY AT WORK/VEHICLE ACCIDENT/OTHER HOW INJURY OCCURRED SAM ORLICH	
34a PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34d LOCATION (Street and Number or Rural Route Number, City or Town, State) LAKELAND COUNTY					
34e DATE PRONOUNCED DEAD (Month Day Year)				34f MOTOR VEHICLE ACCIDENT? (Yes or no) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

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