

099205484 HB

STATE OF INDIANA

County of LAKE~

SS:

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

Key # 17-13-23

99070187 SURVIVORSHIP AFFIDAVIT

99 AUG 23 AM 14

~TERRENCE R. STOREY, of full legal age, being first duly sworn upon his/her oath, deposes and says:

1. That he/she is the owner in fee simple of the following described Real Estate located in Lake County, Indiana:

A part of the East 1/2 of the Southwest 1/4 of the Northeast 1/4 of the Southeast 1/4 of Section 29, Township 36 North, Range 7 West of the 2nd Principal Meridian, located in the City of Hobart, Lake County, Indiana, said portion being more particularly described as follows: Beginning at a point on the South line of the East 1/2 of the Southwest 1/4 of the Northeast 1/4 of the Southeast 1/4 of said Section 29, a distance of 155 feet East of the Southwest corner thereof; thence East along the South line of the East 1/2 of the Southwest 1/4 of the Northeast 1/4 of the Southeast 1/4 of said Section 29, a distance of 92.94 feet; thence North and parallel to the West line of the East 1/2 of the Southwest 1/4 of the Northeast 1/4 of the Southeast 1/4 of said Section 29, a distance of 150 feet; thence West and parallel to the South line of the East 1/2 of the Southwest 1/4 of the Northeast 1/4 of the Southeast 1/4 of said Section 29, a distance of 92.94 feet; thence South 150 feet, to the place of beginning.

2. That said Real Estate was formerly owned as ~ joint tenants ~ tenants by entireties by ~ ROSS M. STOREY and ~ TERRENCE R. STOREY, ~ joint tenant(s) ~ spouse as acquired by deed of conveyance recorded ~ as Instrument Number ~ in the office of the Recorder of Lake County, Indiana.

3. ~ ROSS M. STOREY died on 10-9-98 leaving ~ a ~ no will, and:

(Select Appropriate Paragraph(s))

(A) The marital relationship, which existed between ~, husband, and ~, wife, remained continuously and unbroken from the time they acquired title of said Real Estate until ~ death.

(B) Upon the death of ~, Affiant became the sole owner of the fee simple title to said Real Estate as ~ heir ~ surviving tenancy by the entireties ~ surviving joint tenant.

(C) ~ and ~ were divorced on ~ under cause number ~ in ~ County, ~.

4. The total value of ~ estate, taking into consideration in the evaluation thereof, the value of all his/her gifts in contemplation of death, including all gifts made by him/her in the three (3) years next preceding his/her death, together with the value of all his/her investments in joint properties and estates by entireties, including the Real Estate above described, plus the proceeds of all insurance on his/her life, did not equal or exceed the sum subject to Federal Estate Tax. All funeral expenses, debts of the estate and inheritance tax have been paid.

5. Affiant makes this affidavit for the sole purpose of clarifying the title to the above described real estate and to induce the Auditor of Lake County to correct the records to show that title is in the name of ~ and to induce TICOR TITLE INSURANCE COMPANY to provide title insurance for the above described ~ Real Estate ~ Mortgage Security.

Further Affiant saith not.

Terrence R. Storey
~TERRENCE R. STOREY

STATE OF INDIANA, COUNTY OF LAKE SS:

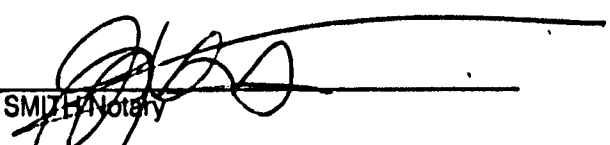
Subscribed and sworn to before me, a Notary Public on this 18TH day of AUGUST

PETER BENJAMIN
LAKE COUNTY AUDITOR

FILED

AUG 20 1999

1999


JACALYN L. SMITH, Notary

My Commission Expires: 12-08-99

County of Residence: LAKE

This document prepared by: TERRENCE M. STOREY



ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.....

Local No. 2247-98

200429

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

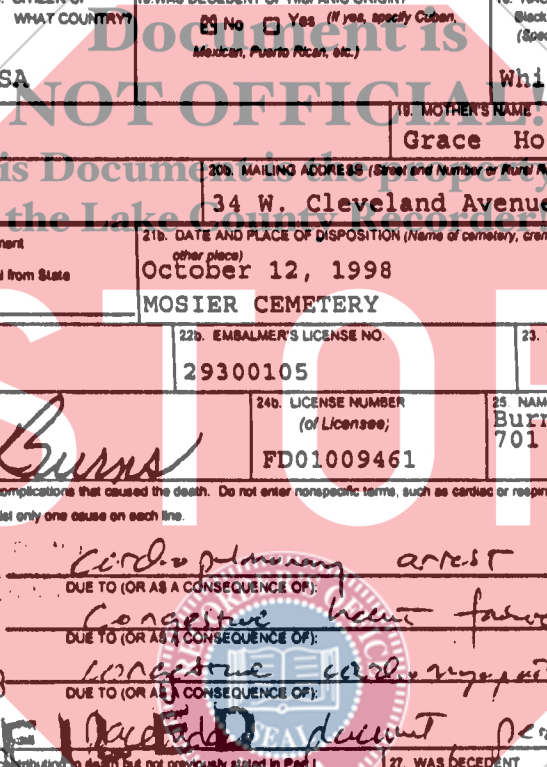
DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) ROSS M. Storey		2. SEX Male		3a. TIME OF DEATH 6:11 AM		3b. DATE OF DEATH (Month, Day, Yr) October 9, 1998	
4. SOCIAL SECURITY NUMBER 310-03-8159		5a. AGE - Last Birthday (Years) 81		5b. UNDER 1 YEAR Months Days 0 0		5c. UNDER 1 DAY Hours Minutes 0 0	
6. DATE OF BIRTH (Mo., Day, Yr.) August 14, 1917		7. BIRTH PLACE (City and State or Foreign Country) Hobart Indiana					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? _____		PLACE OF DEATH (Check only one - See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) 1316 E. Hickey Street				9b. CITY, TOWN, OR LOCATION OF DEATH Hobart		9c. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) N/A		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Steelworker		12b. KIND OF BUSINESS/INDUSTRY U. S. Steel-Gary	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Hobart		13d. STREET AND NUMBER 1316 E. Hickey Street	
13e. ZIP CODE 46342		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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+) N/A					
18. FATHER'S NAME (First, Middle, Last) George Storey				19. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Hollister			
20a. INFORMANT'S NAME (Type/Print) Terrence R. Storey				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 W. Cleveland Avenue, Hobart, IN 46342		20c. Relationship Son	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) October 12, 1998 MOSIER CEMETERY		21c. LOCATION - City or Town, State Valparaiso, Indiana			
22a. EMBALMER'S NAME Russell A. Kraft		22b. EMBALMER'S LICENSE NO. 29300105		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-			
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. Cardiopulmonary arrest Minutes b. Congestive heart failure years c. Congestive cardiomyopathy years Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: OCT 13 1998 ELDERED patient, persistent vascular disease PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I AUG 20 1999							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) 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 In my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER In my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter Benjamin</i> PETER BENJAMIN LAKE COUNTY AUDITOR		29c. MEDICAL LICENSE NO. 31712		29d. DATE SIGNED (Month, Day, Year) 10-13-98	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Jack Ziegler, M.D. 1400 South Lake Park Avenue, Hobart, IN 46342							
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>						32. DATE FILED (Month, Day, Year) October 13, 1998	
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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 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.		001479			



25 x 110