FA# **F29811**
LEGAL DESCRIPTION:
Unit E-8, in Stone Ridge Condominium, a Horizontal Property Regime as recorded under the date of June 14, 1978 as Document Nos. 473672 and 473673, and as amended, in the Office of the Recorder of Lake County, Indiana, and an undivided interest in the common elements appertaining thereto.

First American Title Insurance Company

99062783

PROPERTY ADDRESS:
#E-8 405 Old Stone Road, Munster, IN 46321

ESTATE AFFIDAVIT

ROSEMARY MEYER , Affiant, states that:

1. **EVELYN C. MCCOMB** , deceased, died on the 28 day May of 1999 , ;

2. Affiant is: ☐ the surviving spouse of the deceased,
   ☐ the Personal Representative/Executor-trix of the estate of the deceased;
   ✗ the Successor Trustee by appointment pursuant to The Eveoyn C. McComb Trust No 1 dated Janury 7, 1992.

3. The deceased died: ☐ leaving a will which has been probated;
   ☒ leaving a will which has not been probated;
   ☐ leaving no will;

4. The deceased and Affiant were married on the day of , ; and were never divorced. (This item applies only to the surviving spouse.)

5. ☒ All expenses of the last illness and funeral of the deceased have been paid;

6. ☐ All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. ☒ There have been no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

9-30-99 — Date
Rosemary Meyer Trustee — Signature of Affiant

ROSEMARY MEYER ROSEMARY MEYER
Printed Name of Affiant

State of Indiana, County of **LAKE**

Subscribed and sworn to before me, this **30TH** day of **SEPTEMBER** , **1999** .

CORINA CASTEL RAMOS
Printed Name of Notary

Signature of Notary

My Commission expires: **5-16-01**

My County of Residence is: **PORTER**

000451

THIS INSTRUMENT WAS PREPARED BY: **ROSEMARY MEYER**

HOLD FOR FIRST AMERICAN TITLE

12.00
Ph
78

Vision Form SAFFA1IN Rev. 06/17/99

25 × 10

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1296-99 State No. .....

260610

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
Evelyn C. McComb	Female	1:20A M	May 28,1999

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)
304-14-7006	85			Feb.14,1914	Chicago,IL

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	None	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
hartsfield Village Care Center	Munster	Lake

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
Widow	---	Interior Designer	Home Furnishings

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
IN	Lake	Munster	405 Old Stone Rd. #8

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 +)
46321	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12	--

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Chris Hansen	Alyce N.A.

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
Rosemary Meyer	1119 Cornwallis Ln. Munster,IN	Friend

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c LOCATION—City or Town, State
☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 30,1999 Regional Cremation SV	Munster,IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
---	---	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Thomas J. Burns	1045184	Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN(For Cedar Pk/Chicago,IL Signature Only)

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 x Large tumor of the lumbar spine	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) b	
	DUE TO (OR AS A CONSEQUENCE OF) c	
	DUE TO (OR AS A CONSEQUENCE OF) d	

FILED

OCT 06 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

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)
	No	No	

CERTIFIER

29a CERTIFIER (Check only one)

☒ 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)
x J. Paik, M.D.	x30770	May 31 ,1999

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

J. Paik, M.D. 200 Monticello Dyer,IN 46311

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Alexander S. Pilliod MD	June 2, 1999

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				CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

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)
	JUN 2 1999 000452

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
	Alexander S. Pilliod MD LAKE COUNTY HEALTH OFFICER

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

25x10