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TICOR TITLE INSURANCE

STATE OF INDIANA
LAKE COUNTY
OFFICE FOR RECORDS

MORRIS W. CARTER
RECORDER
AFFIDAVIT

FILED

OCT 15 1999

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

PETER BENJAMIN
LAKE COUNTY AUDITOR

Joyce A. McClellan, being first duly
sworn upon oath, deposes and says:

1. That Howard M. McClellan died on
October 29, 1997 at St. Margaret Mercy Hospital.

2. That Howard M. McClellan and Joyce A. McClellan
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate:

The North 20 feet of Lot 101 and the South 40 feet of Lot 102 in Suburban
Terrace Addition, to the Town of Dyer, as per plat thereof, recorded in
Plat Book 31 page 94, in the Office of the Recorder of Lake County, Indiana.

Document is
Not Officially
This Document is the property of
the Lake County Recorder
Key # 14-104-102

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.

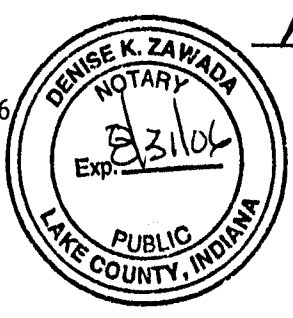
4. That all funeral expenses in connection with the death of said decedent
have been paid in full.

5. 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.

Further affiant sayeth not.

Joyce A. McClellan
JOYCE A. MCCLELLAN

Subscribed and sworn to before me, a Notary Public, this 12th day of
October, 1999.



Denise K. Zawada
Denise K. Zawada Notary Public

My Commission expires: 8-31-06

County of Residence:
Lake

001041

This Instrument prepared by Joyce A. McClellan

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e.p.
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* 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

State No.

Local No. 2257-97
205282

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

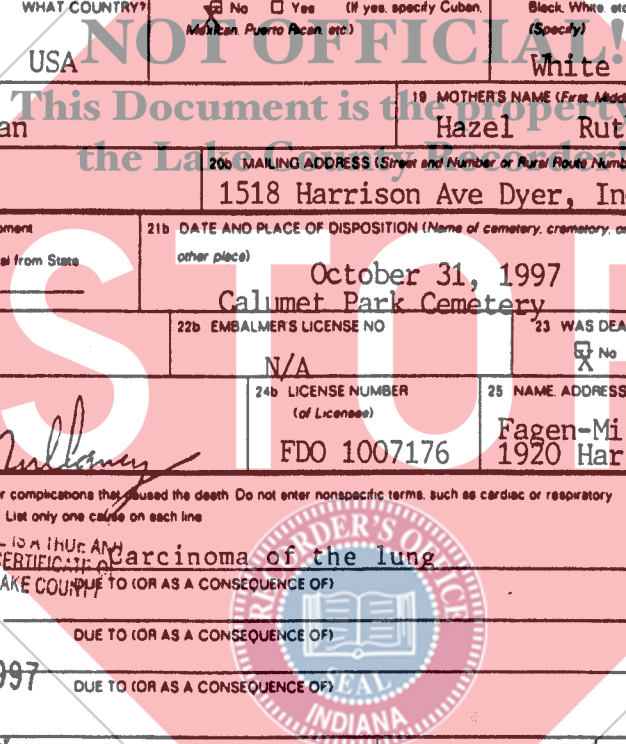
CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First, Middle, Last) Howard M. McClellan		2 SEX Male	3a TIME OF DEATH 3:36P M	3b DATE OF DEATH (Month, Day, Yr) October 29 1997
4 SOCIAL SECURITY NUMBER 365-12-8893	5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Feb. 23, 1920
7 BIRTHPLACE (City and State or Foreign Country) Cass Twp, Sullivan, IN	8a WAS DECEDENT A U.S. VETERAN? Yes			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <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) St Margaret Mercy Hospital-South		9c CITY, TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Joyce A. Barbier	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Payroll Clerk		12b KIND OF BUSINESS/INDUSTRY Steel Co
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Dyer	13d STREET AND NUMBER 1518 Harrison Ave	
13e ZIP CODE 46311	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 2 College (11-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) Ralph McClellan		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Ruth Mitchell		20a INFORMANT'S NAME (Type/Print) Joyce A. McClellan		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 Harrison Ave Dyer, Indiana 46311		20c Relationship Wife		
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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 31, 1997 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana
22a EMBALMER'S NAME Not-Embalmed		22b EMBALMER'S LICENSE NO N/A	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward T. Mullaney</i>		24b LICENSE NUMBER (of Licensee) FDO 1007176	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes Inc 1920 Hart St Dyer, Indiana 46311 FH83001504	
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. Carcinoma of the lung IMMEDIATE CAUSE OF DEATH DUE TO (OR AS A CONSEQUENCE OF) OCT 31 1997 CONDITIONS if any which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions contributing to death but not previously stated in Part I LAKE COUNTY HEALTH COMMISSIONER				
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) 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>[Signature]</i>		29c MEDICAL LICENSE NO 000476	29d DATE SIGNED (Month, Day, Year) 10-30-97	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) William G. Cataldi, D.O., 840 Richard Road, Dyer, IN 46311				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>				32 DATE FILED (Month, Day, Year) October 31, 1997
33 MANNER OF DEATH <input 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 OCCASION (Season and Month 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, bicyclist, etc. OCT 15 1999				

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