

FILED

OCT 22 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

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LAKE COUNTY AUDITOR

Hold Karn

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

3

On this 10-7-99 before me personally appeared James C Ashby Sr
(insert date)

99D87345

to me personally known, who being duly sworn on oath did say that:

- 1. Affiant resides at the address given below affiant's signature;
- 2. Affiant is Owner
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by James C Ashby Sr and Juanita Sarah Ashby

4. Said Juanita Sarah Ashby
(fill in name of co-tenant who died)

died on March 22, 1998

leaving no will;
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:
4436 Magoon Ave E. Chgo, IN 46312

LOTS 35 and 36, in block 27 as marked and laid down on the recorded plat of the subdivision of the northwest 1/4 of section 29, township 37 north, range 9 west of the second principal meridian in lake county, Indiana, as the same appears of record in plat book 2 page 13, in the recorder's office of Lake County, Indiana

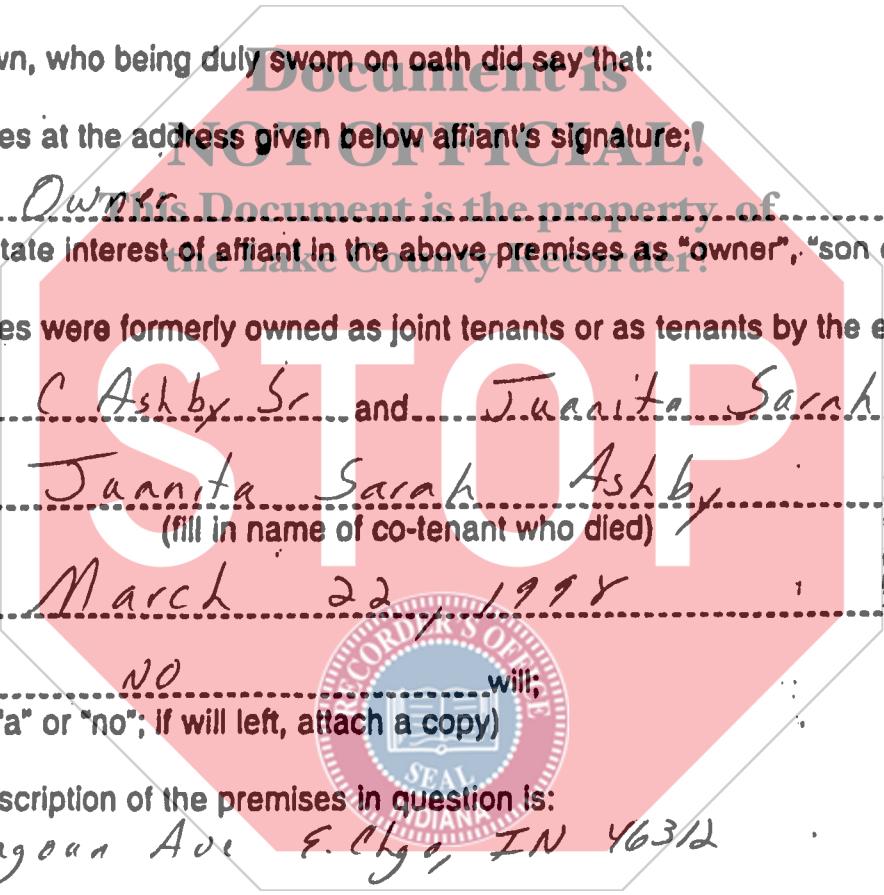
6. Is there Federal Estate or State inheritance tax liability by reason of the death of said

decendent? Yes No

001545

If yes, then estimated taxes due are \$ _____

The taxes due are paid or unpaid.



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDER
99 OCT 22 PM 2:23
KORRIS W. CARTER
RECORDER

*E.P.
CB
13*

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:

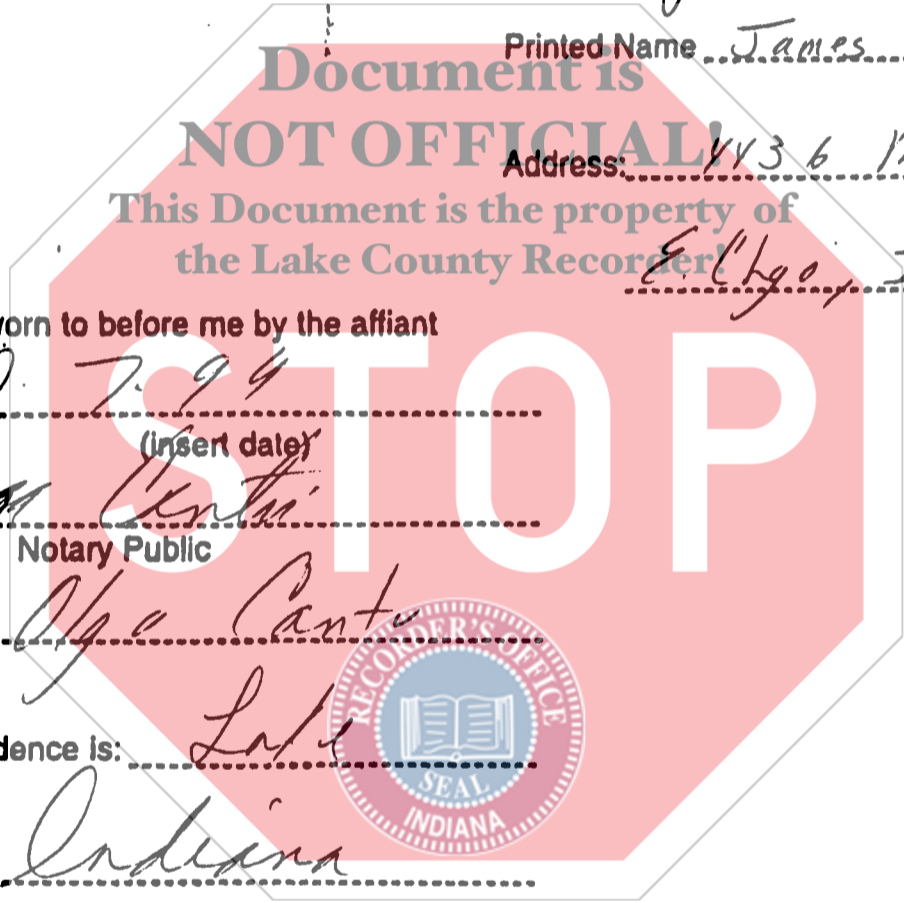
8. Affiant's relationship to the deceased was *husband*

Signature: *James C Ashby Sr*

Printed Name *James C Ashby Sr*

Address: *4436 Mayoun Ave*

Ellettsville, IN 46312



Subscribed and sworn to before me by the affiant

this *10-7-94*
(insert date)

[Signature]
Notary Public

Printed Name *Opal Cantu*

My County of Residence is: *Lake*

In the State of *Indiana*

My Commission Expires *11-12-2001*

This instrument prepared by *Lisa Heredia*

* 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

Local No. 72

State No. _____

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED-NAME (First Middle Last) JUANITA SARAH (TUDOR) ASHBY		2. SEX Female		3. TIME OF DEATH 2:30AM		4. DATE OF DEATH (Month Day Yr) March 22, 1998	
5. SOCIAL SECURITY NUMBER 308-18-7608		6a. AGE - Last Birthday (Years) 77		6b. UNDER 1 YEAR Months Days		6c. UNDER 1 DAY Hours Minutes	
7. DATE OF BIRTH (Mo Day Yr) Aug 17, 1920		8. BIRTHPLACE (City and State or Foreign Country) LOGANSFORT, IN					
9a. WAS DECEDENT A U.S. VETERAN? No		9b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A		9c. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
10. FACILITY NAME (If not institution, give street and number) 4436 MAGOUN AVENUE				11. CITY/TOWN OR LOCATION OF DEATH EAST CHICAGO		12. COUNTY OF DEATH LAKE	
13. MARITAL STATUS (Specify) Married		14. SURVIVING SPOUSE (If wife, give maiden name) JAMES ASHBY, SR.		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		16. KIND OF BUSINESS INDUSTRY OWN HOME	
17a. RESIDENCE - STATE IN		17b. COUNTY LAKE		17c. CITY/TOWN OR LOCATION EAST CHICAGO		17d. STREET AND NUMBER 4436 MAGOUN AVENUE	
18a. ZIP CODE 46312		18b. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		18c. CITIZEN OF WHAT COUNTRY? USA		18d. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	
18e. RACE - American Indian, Black, White, etc. (Specify) WHITE		19. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (9-12) College (1-4 or 5+)					
20. FATHER'S NAME (First, Middle, Last) LEONARD TUDOR				21. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH SMITHERS			
22. INFORMANT'S NAME (Type/Print) JAMES ASHBY, SR.				23. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4436 MAGOUN AVENUE, East Chicago, IN 46312		24. Relationship Husband	
25a. 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)				25b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mar 26, 1998 CHAPEL LAWN MEMORIAL GARDENS		25c. LOCATION - City or Town State Schererville, IN	
26a. EMBALMER'S NAME JOHN C. AULT				26b. EMBALMER'S LICENSE NO. FDO1013507		26c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
27a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				27b. LICENSE NUMBER (of Licensee) FDO1013507		27c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, Hammond, IN 46323	
28. 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) a. Adenocarcinoma of colon DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ DUE TO (OR AS A CONSEQUENCE OF) 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 listed in Part I. Chronic renal failure Leukopenia				29. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		30. WAS AN AUTOPSY PERFORMED? (Yes or no) No	
31. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No							
32. 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.							
33. SIGNATURE AND TITLE OF CERTIFIER <i>Paula Benchik-Abrinko MD</i>				34. MEDICAL LICENSE NO. 01045436		35. DATE SIGNED (Month Day Year) 3/23/98	
36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Paula Benchik-Abrinko, M.D. 1534-119th St. Whiting, IN 46394							
37. HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Raykouch</i>				38. DATE FILED (Month Day Year) 3-23-98			
39. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		40a. DATE OF INJURY (Month Day Year)		40b. TIME OF INJURY		40c. INJURY AT WORK? (Yes or no)	
40d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		40e. LOCATION (Street and Number or Rural Route Number City or Town State)					
41. DATE PRONOUNCED DEAD (Month, Day, Year)				42. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			