Ticor Sch 9926266

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

9909068

TICOR TITLE INSURANCE

99 NOV -3 AM 9:17

FILED

MORRIS W. CARTER
RECORDER

AFFIDAVIT

NOV 02 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Dorothy McQuillan, being first duly sworn upon oath, deposes and says:

1. That James McQuillan died on March 23, 1999 at _____.

2. That James McQuillan and Dorothy McQuillan were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

All of Lot 56 and Lot 55, except the East 11 feet thereof, in Block 6 in Hollywood of Hammond, in the Town of Munster, as per plat thereof, recorded in Plat Book 19 page 21, in the Office of the Recorder of Lake County, Indiana.

Key # 28-58-56.

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.

Dorothy McQuillan
Dorothy McQuillan

Subscribed and sworn to before me, a Notary Public, this 29th day of October, 1999.

DENISE K. ZAWADA NOTARY Exp. 8/31/06 PUBLIC LAKE COUNTY, INDIANA

Denise K. Zawada
Notary Public

My Commission expires:
8/31/2006

000115

County of Residence:
Lake

11.00
E.P.
T.

This Instrument prepared by Dorothy McQuillan

Ticor Sch 99207266

* 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 or refusal.

Local No. 279

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Todorovich

THIS CERTIFIES THE FOLLOWING IS A TRUE & COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

S Date Issued AUG 10, 1999

Franklin D. Bermudez
Hammond Health Commissioner

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.)
James McQuillan	Male	3:23A M	March 23,1999

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)
190-09-4761	87			Aug.5,1911	Pittsburg,PA

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
St. Margaret Mercy Healthcare	Hammond	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
Married	Dorothy Barnes	Metalugist	Nonferrous Refinery

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
IN	Lake	Munster	216 Fairbanks Pl.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN?	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
46321	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+): 4

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Patrick McQuillan	DeSales Ingoldsby

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
Dorothy McQuillan	216 Fairbanks Pl. Munster,IN46321	Wife

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)	March 25,1999 Chapel Lawn Memorial Gardens	Schererville,IN

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
John T. Noble	9000031	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
	1021590	Burns-Kish Funeral Home#300496 8415 Calumet MUnster,IN 46321

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. PULMONARY FIBROSIS	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

FILED
NOV 02 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	-- 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)
	10314415	March 26,1999

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
M. Hussain, M.D. 8032 Kennedy Ave. Highland,IN 46322

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Bermudez M.D.	March 26 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				000116

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.

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