

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 014582

2000 MAR -1 FILED 12:30

TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

AFFIDAVIT

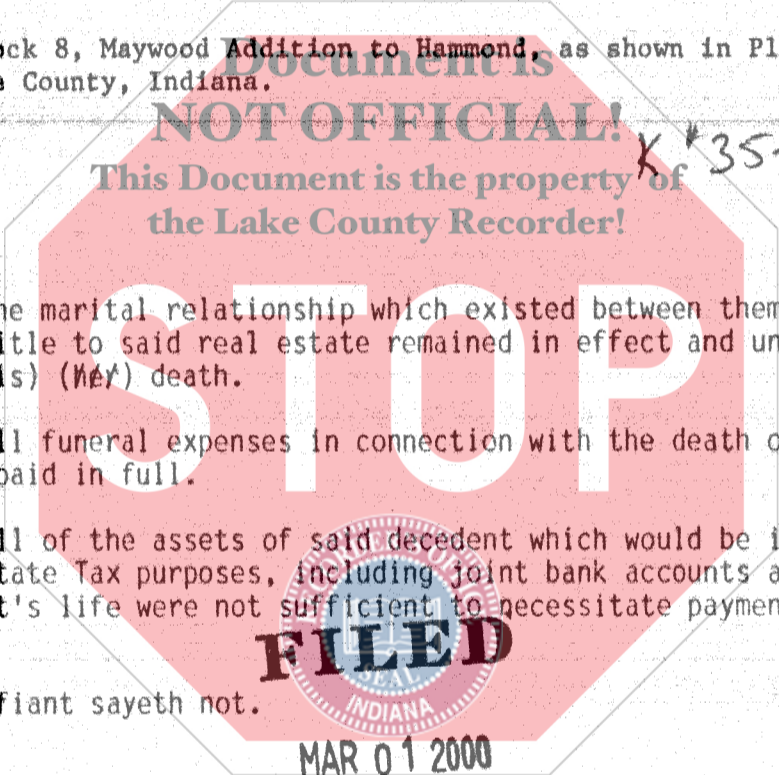
STATE OF INDIANA)
COUNTY OF LAKE) SS:

Cynthia Johnson, being first duly
sworn upon oath, deposes and says:

1. That Willie Johnson died on
January 16, 19 98 at Munster, IN.

2. That Cynthia Johnson and Willie Johnson
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate:

Lot 14, Block 8, Maywood Addition to Hammond, as shown in Plat Book 11 page
32, in Lake County, Indiana.



X*35-60-14

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.

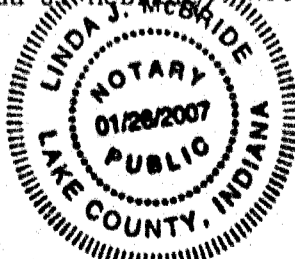
Further affiant sayeth not.

PETER BENJAMIN
LAKE COUNTY AUDITOR

Cynthia Johnson

Subscribed and sworn to before me, a Notary Public, this 16th day of
February, 19 2000.

Linda J. McBride
Notary Public



My Commission expires:

1-26-07

County of Residence:

Lake

This Instrument prepared by Cynthia Johnson

11.00
EM

mO
20929 CW

CITYWIDE TITLE

00119

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. 0099-98

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

256801
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) MR WILLIE J JOHNSON		2 SEX MALE	3a TIME OF DEATH 00:29	3b DATE OF DEATH (Month, Day, Yr) NOV 16, 1998
4 *SOCIAL SECURITY NUMBER 98-04168 310-38-6068		5a UNDER 1 YEAR Months Days	5b UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) MARCH 27, 1938
7 BIRTHPLACE (City and State or Foreign Country) ALABAMA		8a 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		
8b WAS DECEDENT A U.S. VETERAN? NO		8c YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8d CITY, TOWN, OR LOCATION OF DEATH MUNSTER
8e FACILITY NAME (If not institution, give street and number) COMMUNITY HOSPITAL		8f COUNTY OF DEATH LAKE		
10 MARITAL STATUS MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) CYNTHIA DYE		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) CATCHER
12b KIND OF BUSINESS/INDUSTRY STEEL INDUSTRY				
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION HAMMOND
13d ZIP CODE		13e ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		13f STREET AND NUMBER 1129 LYONS STREET
14 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14a CITIZEN OF WHAT COUNTRY? U.S.A.		14b RACE—American Indian, Black, White, etc. (Specify) BLACK AMER.
14c ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH. GRADE College (1-4 or 5+)
18 FATHER'S NAME (First, Middle, Last) JAMES JOHNSON		18 MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE JOHNSON		
20a INFORMANT'S NAME (Type/Print) CYNTHIA JOHNSON		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 LYONS STREET, HAMMOND, IND.		20c Relationship WIFE
21a 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)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) JANUARY 23, 1998 Fern Oaks Cemetery		21c LOCATION—City or Town, State GRIFFITH, INDIANA
22a EMBALMER'S NAME LUTHER L. JACKSON		22b EMBALMER'S LICENSE NO. FD 29300079		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of licensee) GLEN PARK MEM. CHAPEL 1940008 4207 BROADWAY, GARY, INDIANA		
25 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. Use only one cause on each line. CARCINOMA of prostate		Approximate Interval Between Onset and Death Onk		
IMMEDIATE CAUSE (Final disease or condition resulting in death) CARCINOMA of prostate		FILED		
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last JAN 20 1998		DEC 23 1998		
PART II: Other significant conditions, Conditions contributing to death but not previously stated in Part I LAKE COUNTY HEALTH COMMISSIONER		27 WAS DECEDENT PREGNANT OR POSTPARTUM? N/A		28a WAS AN AUTOPSY (Yes or no) NO
		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A		
29a CERTIFIER (Check only one) <input 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) and manner 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 Frank R. Heber		29c MEDICAL LICENSE NO. 01019341
		29d DATE SIGNED (Month, Day, Year) 1-20-98		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29 type/Print) 7550 Hohman - Munster Ind - Dr. Frank Heber		32 DATE FILED (Month, Day, Year) January 20, 1998		
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				
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 LOCATION (Street and Number or Rural Route Number, City or Town, State) 001887
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		

NOT OFFICIAL

This Document is the property of the Indiana State Department of Health

FILED

INDIANA

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

HEALTH OFFICER

HEALTH OFFICER

HEALTH OFFICER

HEALTH OFFICER

35-60-14 & 35-106-30

905
100

25x117