STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 014582

2000 MAR -1 PM 12:30

TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

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.

Cynthia Johnson

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

Linda J. McBride, Notary Public

LINDA J. McBRIDE NOTARY PUBLIC 01/26/2007 LAKE COUNTY, INDIANA

My Commission expires:

1-26-07

County of Residence:

Lake

This Instrument prepared by Cynthia Johnson

11.00

20929 CW CITYWIDE TITLE

* 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.

Local No. 6099-98

256801

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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): WILLIE J. JOHNSON
2. SEX: MALE
3a. TIME OF DEATH: 11:00AM
3b. DATE OF DEATH (Month Day Yr): JANUARY 16, 1998
4. SOCIAL SECURITY NUMBER: 310-38-6068
5a. AGE—Last Birthday (Years): 59
5b. UNDER 1 YEAR (Months / Days)
5c. 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. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): 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. STREET AND NUMBER: 1129 LYONS STREET
13e. ZIP CODE:
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): BLACK AMER.
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+): 12TH. GRADE

PARENTS

18. FATHER'S NAME (First, Middle, Last): JAMES JOHNSON
19. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE JOHNSON

INFORMANT

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

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] 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?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee)
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: GLEN PARK MEM. CHAPEL 19400008 4207BROADWAY, GARY, INDIANA

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. Carcinoma of Prostate — Unknown

DUE TO (OR AS A CONSEQUENCE OF) b.

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

DUE TO (OR AS A CONSEQUENCE OF) d.

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.

27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

I CERTIFY THIS IS A TRUE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JAN 20 1998
[signature] M.D.
LAKE COUNTY HEALTH COMMISSIONER

FILED
DEC 25 1998
SAM ORLICH
AUDITOR LAKE COUNTY

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) and manner 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: Frank R. Hieber
29c. MEDICAL LICENSE NO: 01019344
29d. DATE SIGNED (Month Day Year): 1-20-98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. FRANK HIEBER 7550 Hohman - Munster Ind 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month Day Year): January 20, 1998

33. MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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)
34g. DATE PRONOUNCED DEAD (Month Day Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

001883

#35-60-14 & 35-106-30

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