

3-17

AFFIDAVIT OF HEIRSHIP STATE OF INDIANA LAKE COUNTY

STATE OF IN

FILED 3-13-00

COUNTY OF LaRue 020737

2000 MAR 13 04:22:27

Faye Cox RELATIONSHIP TO DECEASED Family Friend BEING DULY SWORN, FOR THE PURPOSE OF INDUCING NATIONAL EQUITY TITLE COMPANY TO ISSUE ITS TITLE INSURANCE POLICY COVERING THE LAND DESCRIBED IN THE ABOVE CAPTIONED COMMITMENT, DEPOSES AND SAYS;

1. THAT Faye Cox NOW RESIDES AT 700 Grant St Gary IN, BEING THE PROPERTY IN QUESTION.

SEE ATTACHED EXHIBIT "A" FOR LEGAL DESCRIPTION.

2. THAT HE/SHE WAS ACQUAINTED WITH James Buchanan WHO DIED ON Feb 24, 2000, AS EVIDENCE BY THE ATTACHED CERTIFIED COPY OF DEATH CERTIFICATE.

3. THAT SAID DECEDENT WAS ONE OF THE OWNERS OF THE LAND DESCRIBED IN THE ABOVE CAPTIONED COMMITMENT.

4. THAT SAID DECEDENT DIED:

LEAVING NO LAST WILL AND TESTAMENT.

LEAVING A LAST WILL AND TESTAMENT, A COPY OF WHICH IS ATTACHED.

5. THAT SAID DECEDENT HAD NO CHILDREN OUT OF WEDLOCK.

6. THAT THE HEIRS AND DISTRIBUTERS, AND THEIR RELATION, OF DECEDENTS ESTATE ARE AS FOLLOWS:

Shawn Buchanan "only son"

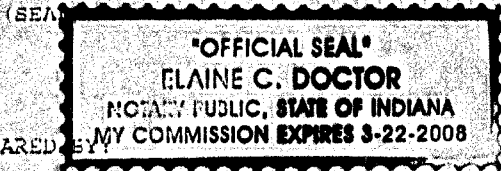
6. THAT ALL DECEDENTS DEBTS INCLUDING PUBLIC OLD AGE ASSISTANCE ADVANCEMENTS, FUNERAL, DOCTOR AND HOSPITAL BILLS HAVE BEEN PAID IN FULL.

7. THAT THE TOTAL VALUE OF SAID DECEDENTS ESTATE FOR THE STATE OF INDIANA INHERITANCE TAX/ESTATE TAX AND FEDERAL ESTATE TAX DOES NOT EXCEED

\$ 0

Faye Cox
AFFIDANT'S SIGNATURE

SUBSCRIBED AND SWORN TO ME THIS 13th DAY OF March.



Elaine C. Doctor
NOTARY SIGNATURE

Elaine C. Doctor
NOTARY PRINTED

PREPARED BY

2035

14.50
7/22/07
REC'D

Appendix A

THE EAST 36 FEET OF LOT 2, AND THE WEST 18 FEET OF LOT 3, BLOCK 17, IN GARY LAND COMPANY'S
FOURTH SUBDIVISION, IN THE CITY OF GARY, AS SHOWN IN PLAT BOOK 14, PAGE 15, IN LAKE
COUNTY, INDIANA.



INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

ICD-10 No. 00.0165

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IO 10-1-10-9

REPRINT IN PERMANENT INK

DECEDENT

EVENTS

DECEASED

POSITION

CAUSE

IN

1 DECEASED—NAME (Full Name Last, First, Middle Initial) James Buchanan		2 SEX Male	3 TIME OF DEATH 9:30 A	4 DATE OF DEATH (Month Day Year) February 24, 2000
5 FEDERAL SOCIAL SECURITY NUMBER 333-28-1213	6 AGE—Last Birthday (Month Day Year) 63	7 MARRIAGE STATUS Married	8 DATE OF BIRTH (Month Day Year) March 6, 1936	9 BIRTHPLACE (City and State or Foreign Country) Mississippi
10 WAS DECEASED A U.S. VETERAN? NO	11 YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	12 PLACE OF DEATH (Name and Address of Institution) HOSPITAL <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> XCR		
13 FACILITY NAME (If not institution give street and number) 2025 West 5th Avenue		14 CITY/TOWN OR LOCATION OF DEATH Gary	15 COUNTY OF DEATH Lake	
16 MARRITAL STATUS Married	17 SURVIVING SPOUSE Barbara Bennett	18 DECEASED'S USUAL OCCUPATION (Give title of work or profession if the decedent was not self-employed) RETIRED	19 KIND OF BUSINESS/INDUSTRY Self-employed	
20 RESIDENCE—STATE Indiana	21 COUNTY Lake	22 CITY/TOWN OR LOCATION Gary	23 STREET AND NUMBER 2025 West 5th Avenue	
24 ZIP CODE 46404	25 HOME CITY LISTED <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	26 CITIZENSHIP USA	27 WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	28 RACE—American Indian or Alaska Native Black
29 FATHER'S NAME (Full Name Last) James Buchanan		30 MOTHER'S NAME (Full Name Last) Lucille Boykin		
31 DECEASED'S NAME (Full Name) Barbara Buchanan		32 MARITAL ADDRESS (Street and Number or Rural Route Number, City or Town Name, State, Zip Code) 2025 West 5th Avenue Gary, Indiana 46404	33 DECEASED'S RELATIONSHIP TO DECEASED Wife	
34 METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Other <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)		35 DATE AND PLACE OF DISPOSITION (Name of cemetery, church, or other place) February 27, 2000 Oak Hill Cemetery	36 LOCATION—City or Town Name Gary, Indiana	
37 SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		38 LICENSE NUMBER OF LICENSEE #01051701	39 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue GARY, Indiana 46404 83007704	
40 PART I: State the immediate cause of death and the cause for which the death was the direct result. Do not over-abbreviate. Write full name of organ or system. Abbreviate organs and systems only. Do not use "and" or "with".		41 APPROVED IMPROVED SIGNATURE (Date and Time) 2/24/00		
42 IMMEDIATE CAUSE (Full name of organ or system resulting in death) Malignant Non Hodgkin's Lymphoma with		43 DUE TO (or AS A CONSEQUENCE OF) Chronic Lymphocytic Leukemia		
44 CAUSE (Full name of organ or system resulting in death) SIP chemo. of Bone metastasis		45 DUE TO (or AS A CONSEQUENCE OF) SIP Radio. of Bone metastasis		
46 PART II: Other significant conditions - Conditions contributing to death are not immediately causes - Part I		47 WAS DECEASED PRESENT ON 90 DAYS RESTRAINT? NO		
48 WAS DECEASED PRESENT ON 90 DAYS RESTRAINT? NO		49 WAS AN AUTOPSY REPORTED? NO		50 WERE AUTOPSY FINDINGS AVAILABLE FROM TO COMPLETION OF CAUSE OF DEATH? (Yes or No) NO
51 CERTIFIER (Check only one) <input type="checkbox"/> PHYSICIAN To the best of my knowledge, death occurred as the result of the cause and effect and due to the condition so stated. <input type="checkbox"/> HEALTH OFFICER On the basis of information given or investigation in my official capacity, death occurred as the result of the cause and effect and due to the condition so stated. <input type="checkbox"/> CORONER On the basis of information given or investigation in my official capacity, death occurred as the result of the cause and effect and due to the condition so stated.		52 SIGNATURE AND TITLE OF CERTIFIER Jyotana Sanghvi MD		
53 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If not a physician) 0127 Merrillville Rd Merrillville, IN 46410		54 MEDICAL LICENSE NO. 01035695	55 DATE SIGNED (Month Day Year) February 28, 2000	
56 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		57 DATE FILED (Month Day Year) FEB 24 2000		
58 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/> Other (Specify)		59 DATE OF INJURY (Month Day Year) MAR 6 1936	60 TIME OF INJURY (Year of Day) 1936	61 BECAME HOW INJURED? ...
62 PLACE OF INJURY (Name and Address of Institution, Factory, Office, or Home) ...		63 LOCATION (Street and Number or Rural Route Number, City or Town Name) ...		
64 DATE PROHOUNCED DEAD (Month Day Year) ...		65 MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. ...		