FA# F31245

STATE OF INDIANA
LAKE COUNTY
FILED

LEGAL DESCRIPTION:
The West 60 Feet of Lot 54 in Suburban Terrace Addition to the Town of Dyer, as per plat thereof, recorded in Plat Book 31, Page 94, in the Office of the Recorder of Lake County, Indiana

2000 022070

First American Title Insurance Company

PROPERTY ADDRESS:
501 Coral Drive, Dyer, IN 46311

ESTATE AFFIDAVIT

GRACIE SHECKLES, Affiant, states that:

1. **JAMES SHECKLES**, deceased, died on the 12th day August of 1992 ;

2. Affiant is: ✓ the surviving spouse of the deceased,
   ☐ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ☐ leaving a will which has been probated;
   ☐ leaving a will which has not been probated;
   ☒ leaving no will;

4. The deceased and Affiant were married on the 14th day February of 1943 ; and were never divorced. (This item applies only to the surviving spouse.)

5. ✓ All expenses of the last illness and funeral of the deceased have been paid;

6. ✓ All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. ✓ There have been no claims against the estate of the decedent.

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FILED
MAR 31 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

3/22/00 ______________________ X Gracie Sheckles
Date Signature of Affiant

GRACIE SHECKLES
____
Printed Name of Affiant

State of Indiana, County of **LAKE**

Subscribed and sworn to before me, this **22ND** day of **MARCH, 2000.**

KIM A. DIAZ
____
Printed Name of Notary

Kim A. Diaz
____
Signature of Notary

My Commission expires: **2/15/07**

My County of Residence is: **LAKE**

THIS INSTRUMENT WAS PREPARED BY: **G. SHECKLES**

1.00
S.F.
FA

HOLD FOR FIRST AMERICAN TITLE

Vision Form SAFFA1IN Rev 06/17/99

Local No. 1720-92

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1 DECEASED—NAME (First Middle Last)	JAMES F. SHECKLES
2 SEX	Male
3a TIME OF DEATH	9:20 AM
3b DATE OF DEATH (Month Day Yr)	August 12, 1992
4 SOCIAL SECURITY NUMBER	411-28-6756
5a AGE—Last Birthday (Years)	70
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo Day Yr)	July 24, 1922
7 BIRTHPLACE (City and State or Foreign Country)	La Follette, Tennessee
8a WAS DECEDENT A U.S. VETERAN?	Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?	1943
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)	St. Margaret-Mercy - Southlake
9c CITY, TOWN, OR LOCATION OF DEATH	Dyer
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Married
11 SURVIVING SPOUSE (If wife, give maiden name)	Gracie Jean Byrge
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Boiler Operator
12b KIND OF BUSINESS/INDUSTRY	Chemical Company
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN, OR LOCATION	Dyer
13d STREET AND NUMBER	501 Coral Drive
13e ZIP CODE	46311
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	3
College (1-4 or 5+)	

PARENTS

Field	Entry
18 FATHER'S NAME (First, Middle, Last)	Lafatte Sheckles
19 MOTHER'S NAME (First, Middle, Maiden Surname)	Levina Graves

INFORMANT

Field	Entry
20a INFORMANT'S NAME (Type/Print)	Gracie Jean Sheckles
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	501 Coral Drive, Dyer, IN. 46311
20c Relationship	Wife

DISPOSITION

Field	Entry
21a METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	August 15, 1992 Bakers Forge Cemetery
21c LOCATION—City or Town, State	La Follette, Tenesse
22a EMBALMER'S NAME	Larry D. Anthony
22b EMBALMER'S LICENSE NO	01001447
23 WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR	Larry D. Anthony (signature)
24b LICENSE NUMBER (of Licensee)	01001447
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Anthony & Dziadowicz F.H. 83002916, 9445 Calumet Ave., 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. Congestive heart failure - Hypertensive Heart disease

DUE TO (OR AS A CONSEQUENCE OF): b. [illegible] - Aortic Stenosis Mitral insufficiency

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

DUE TO (OR AS A CONSEQUENCE OF): c. Congestive [illegible]

DUE TO (OR AS A CONSEQUENCE OF):

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	-

CERTIFIER

29a CERTIFIER (Check only one)
- [X] 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

Field	Entry
29b SIGNATURE AND TITLE OF CERTIFIER	(signature)
29c MEDICAL LICENSE NO	01026158
29d DATE SIGNED (Month, Day, Year)	August 13, 1992
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Adela M. Perez, M.D., 2156 Hart, Dyer, Indiana 46311

HEALTH OFFICER

Field	Entry
31 HEALTH OFFICER'S SIGNATURE	Alexander S. Williams, M.D.
32 DATE FILED (Month, Day, Year)	August 13, 1992

CORONER USE ONLY

33 MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide

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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

AUG 13 1992

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

SEAL INDIANA

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SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1