COMMUNITY TITLE COMPANY

— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

2000 030843

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 MAY -5 AM 10:55

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

CTC 19371

JEANETTE J. JACKSON, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, THOMAS N. JACKSON died (without leaving a will) (leaving a will) on June 9 1989 at Munster, Indiana

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

THE WEST 50 FEET OF LOT 2 IN MOTT AND WILTSEE'S CALUMET AVE. ADD. TO HAMMOND, AS PER PLAT THEREOF, RECORDED MAY 15, 1922 IN PLAT BOOK 15 PAGE 16, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 929 170th ST., HAMMOND, IN. 46324

UNIT 26 KEY NO. 35-122-2

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 [illegible] sufficient to necessitate payment of Federal Estate ~~Tax~~.

FILED

MAY 01 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

Further affiant sayeth not.

Jeanette J. Jackson
JEANETTE J. JACKSON

Subscribed and sworn to before me, a Notary Public, this 21 day of April, ~~19~~2000.

COMMUNITY TITLE COMPANY
FILE NO L 19341 MV

Notary Public

My Commission expires:

JENNIFER M. PARKES
MY COMMISSION # CC 677164
EXPIRES: September 3, 2001
Bonded Thru Notary Public Underwriters

County of Residence:

Palm Beach

00125

This Instrument prepared by PATRICK MC MANAMA, ATTORNEY AT LAW
ID 9534-45

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STOP

INDIANA STATE BOARD OF HEALTH

Local No. 3030-89 **CERTIFICATE OF DEATH** State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First / Middle / Last)	2 SEX	3 DATE OF DEATH (Mo. Day. Yr.)
Thomas N. Jackson	Male	June 9, 1989

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 (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
441-12-0021	74			April 28, 1915	Oklahoma City, Oklahoma

8 YEAR LAST SERVED IN US ARMED FORCES? 1946

9a PLACE OF DEATH (Check only one. See instructions) — HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☒ Nursing Home ☐ Residence ☐ Other (Specify)

9b FACILITY NAME (If not institution give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Munster Med-Inn	Munster	Lake

10 MARITAL STATUS—Married / Never Married / Widowed / Divorced (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	Jeanette Therault	Cab driver	Yellow Cab Co.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	929-170 Street

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes Specify	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
yes	no	46324		White	8	

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
General Jackson	

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
Jeanette Jackson	929-170 St., Hammond, Indiana 46324	Wife

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	June 13, 1989 Chapel Lawn Memorial Gardens	Schererville, Indiana

21a SIGNATURE OF FUNERAL DIRECTOR	21b LICENSE NUMBER (of Licensee)	22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
John A Brejin	FD# 1007231	SOLAN FUNERAL HOME FH# 3002893 7109 Calumet Ave., Hammond, Ind. 46324

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only if last certifying physician is not available at time of death to certify cause of death

23a To the best of my knowledge death occurred at the time, date, and place stated. Signature and Title	23b LICENSE NUMBER	23c DATE SIGNED (Month, Day, Year)
[illegible], MD	IN 20248	6/11/89

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

24 TIME PRONOUNCED DEAD (Month, Day, Year): June 9, 1989

26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): no

SEE INSTRUCTIONS

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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)	Cerebrovascular Accident	
DUE TO (OR AS A CONSEQUENCE OF)	Arteriosclerosis	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		
DUE TO (OR AS A CONSEQUENCE OF)		

APR 18 2000

Alan Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

FILED
MAY 01 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease

Diabetis Mellitis - Type I — Diabetis Mellitis Type II

28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

SEE INSTRUCTIONS

CERTIFIER

29a CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER ☐ CORONER ☐ 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

29b SIGNATURE AND TITLE OF CERTIFIER	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
[illegible], MD	IN 20248	6/11/89

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): WV Hellmann, MD 7505 Calumet Ave Munster IN 41321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]

32 DATE FILED (Month, Day, Year): JUN 13, 89

CORONER OR MEDICAL EXAMINER USE ONLY

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
			N/S

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)

SBH06-004 State Form 10110 Rev 10/87 DEATH/PD I

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