

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD



# TICOR TITLE INSURANCE

MORRIS W. CARTER  
RECORDER

2000 050655

## AFFIDAVIT

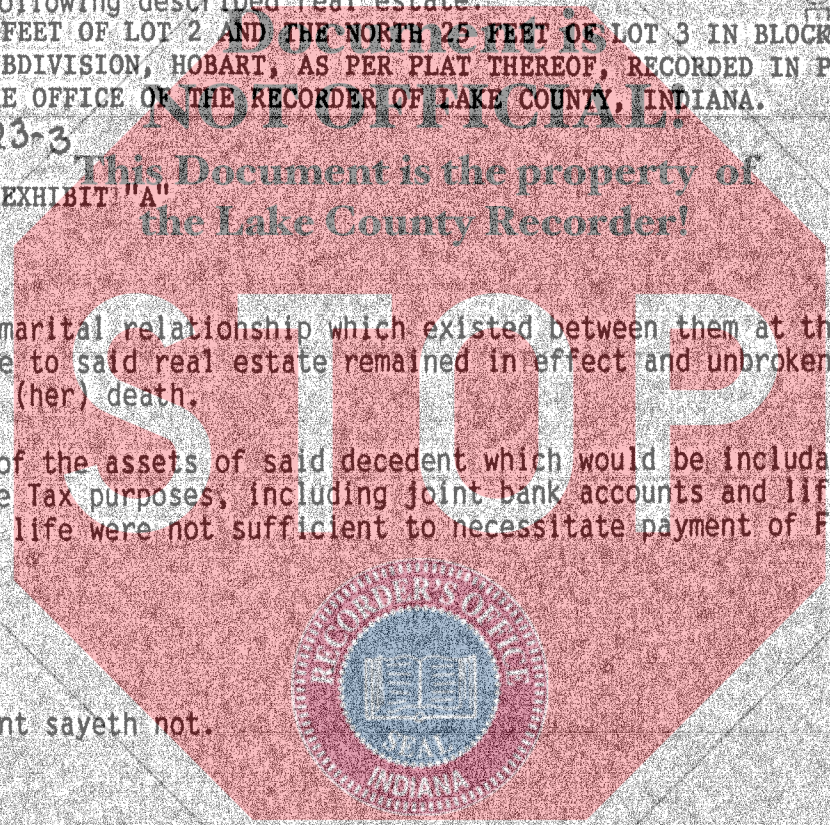
STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

BETTY ANNE SUFANA, being first duly  
sworn upon oath, deposes and says:

1. That RAYMOND C. SUFANA died on  
OCTOBER 5, 19 98 at 10:50AM
2. That RAYMOND C. SUFANA and BETTY ANNE SUFANA  
were duly and legally married at the time they acquired title as husband and  
wife to the following described real estate:  
THE SOUTH 25 FEET OF LOT 2 AND THE NORTH 25 FEET OF LOT 3 IN BLOCK 4 IN HOBART  
LAKE SHORE SUBDIVISION, HOBART, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 21  
PAGE 9, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Key # 18-23-3

SEE ATTACHED EXHIBIT "A"



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 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.

*Betty Anne Sufana*  
BETTY ANNE SUFANA

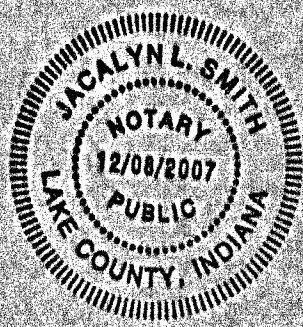
Subscribed and sworn to before me, a Notary Public, this 14TH day of  
JULY, 2000

**FILED**

*Peter Benjamin*  
PETER BENJAMIN  
LAKE COUNTY AUDITOR

My Commission expires:

County of Residence:



00961

This Instrument prepared by BETTY ANNE SUFANA

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TI Ac

92-3059 16  
TICOR TITLE INSURANCE  
Crown Point, Indiana

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
MORRIS W. CARTER  
RECORDER  
2000 JUL 14 AM 9 21



\* ATTENTION ESTATE: Disclosure of the \$5% we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

EXHIBIT "A"  
INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No. 2213-98

State No. ....

282165

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) <b>RAYMOND C SUFANA</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>10:50 AM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>October 5, 1998</b>
4. SOCIAL SECURITY NUMBER <b>310-22-2606</b>	5a. AGE - Last Birthday (Years) <b>72</b>	5b. UNDER 1 YEAR Months _____ Days _____ Hours _____ Minutes _____	5c. UNDER 1 DAY Hours _____ Minutes _____	6. DATE OF BIRTH (Mo., Day, Yr.) <b>April 22, 1926</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>ALLIANCE Ohio</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>		PLACE OF DEATH (Check only one - See instructions)		
9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary Medical Center</b>		9b. CITY, TOWN, OR LOCATION OF DEATH <b>Hobart</b>		9c. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>BETTY</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>ATTORNEY</b>		12b. KIND OF BUSINESS/INDUSTRY <b>LAW</b>
13a. RESIDENCE - STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>HOBART</b>	13d. STREET AND NUMBER <b>205 S. VIRGINIA</b>	
13e. ZIP CODE <b>46342</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	16. RACE - American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed)		17. DECEDENT'S EDUCATION (Specify only highest grade completed)		
Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+) <b>5+</b>		
18. FATHER'S NAME (First, Middle, Last) <b>JOHN SUFANA</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY BUZEA</b>		
20a. INFORMANT'S NAME (Type/Print) <b>BETTY SUFANA</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 S. VIRGINIA, HOBART, IN 46342</b>		20c. Relationship <b>WIFE</b>
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) <b>October 8, 1998 Calumet Park Cemetery</b>		21c. LOCATION - City or Town, State <b>Merrillville, Indiana</b>
22a. EMBALMER'S NAME <b>RUSSELL KRAFT JR.</b>		22b. EMBALMER'S LICENSE NO. <b>29300105</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01009461</b>		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns Funeral Home FH83002445 10101 Broadway, Crown Point, Indiana 46307-8801</b>
25. 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. <b>Pulmonary embolism</b>				Approximate Interval Between Onset and Death <b>Yrs.</b>
IMMEDIATE CAUSE (Etiology) - THE ABOVE IS A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH AS A RESULT OF THE DISEASE OR CONDITION LISTED ABOVE. HEALTH DEPT. FILE WITH THE LAKE COUNTY HEALTH DEPT. <b>OCT 08 1998</b>				
PART II - Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>Alexander S. Williams MD LAKE COUNTY HEALTH COMMISSIONER</b>				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NA</b>
29a. CERTIFIER (Check only one) <input checked="" 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) 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) as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. Devanathan</b>		29c. MEDICAL LICENSE NO. <b>01040141</b>
29d. DATE SIGNED (Month, Day, Year) <b>10/7/98</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20)(Type/Print) <b>DR. RAJA G. DEVANATHAN 1600 S. LAKE PARK AVE., HOBART, IN</b>		
31. HEALTH OFFICER'S SIGNATURE <b>Alexander S. Williams MD</b>		32. DATE FILED (Month, Day, Year) <b>October 8, 1998</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> 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) <b>October 5, 1998</b>		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.		