2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 JUL 19 AM 10:35

MORRIS W. CARTER
RECORDER

First American Title Insurance Company

File No. F32229 2000 050831

Property Address: 3002 McAfee Court
Hobart IN 46342

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

Mary S. Clay . Affiant, states that:

1. Thomas H. Clay . deceased, died on the 10th . day of February , 1997 ;

2. Affiant is: X . the surviving spouse of the deceased,

_____ . the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: X . 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 25th . day of October , 1989 ; and were never divorced. (This item applies only to the surviving spouse.)

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

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

7. Yes . There are no claims against the estate of the descendent.

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

JUL 12 2000
Date

Mary S. Clay
Signature of Affiant Mary S Clay

Mary S. Clay
Printed Name of Affiant

State of Indiana, County of Porter .

Subscribed and sworn to before me, this 12TH day of JULY , 2000 .

" NOTARY SEAL "
Lori S. Monahan, Notary Public
Porter County, State of Indiana
My Commission Expires 7/12/2007

Printed Name of Notary

Lori S Monahan
Signature of Notary

My commission expires:

My County of Residence is:

This Instrument prepared by: Mary S. Clay

FILED
JUL 19 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

F32229 lsm HOLD FOR FIRST AMERICAN TITLE

91075

11.00
AM

This Document Not Valid Unless Stamped on Reverse Side and Embossed With Raised Seal of Porter County

PORTER COUNTY

CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

7.11.20

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): THOMAS H. CLAY
2. SEX: MALE
3a. TIME OF DEATH: 11:00 PM
3b. DATE OF DEATH (Month, Day, Yr): FEBRUARY 10, 1997
4. SOCIAL SECURITY NUMBER: 301-28-1482
5a. AGE—Last Birthday (Years): 62
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): DEC. 20, 1934
7. BIRTHPLACE (City and State or Foreign Country): VONVOY, OHIO
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: --
8c. PLACE OF DEATH (Check only one): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9a. FACILITY NAME (If not institution, give street and number): PORTER MEMORIAL HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: VALPARAISO
9d. COUNTY OF DEATH: PORTER
10. MARITAL STATUS (Married): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): MARY S. DAUB
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): EDUCATOR
12b. KIND OF BUSINESS/INDUSTRY: MUSIC
12d. RESIDENCE—STATE: INDIANA
12e. COUNTY: LAKE
12c. CITY, TOWN, OR LOCATION: HOBART
12f. STREET AND NUMBER: 3002 McAFEE COURT
12g. ZIP CODE: 46342
13. INSIDE CITY LIMITS?: [ ] No [X] Yes
13a. 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): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 8

PARENTS

18. FATHER'S NAME (First, Middle, Last): WILLIAM FORD CLAY
19. MOTHER'S NAME (First, Middle, Maiden Surname): KREA LOUISE KREISCHER

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MARY S. CLAY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3002 McAFEE COURT, HOBART, IN. 46342
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 14, 1997 I. O. O. F. CEMETERY
21c. LOCATION—City or Town, State: CONVOY, OHIO
22a. EMBALMER'S NAME: GORDON L. JONES
22b. EMBALMER'S LICENSE NO: 01010711
22. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
23a. SIGNATURE OF FUNERAL DIRECTOR: Terrence R. Burns
23b. LICENSE NUMBER (of Licensee): 01013890
23. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME FDH# 83002380, 701 E. 7TH STREET, HOBART, IN. 46342

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Acute Ascending Aortic Dissection
DUE TO OR AS A CONSEQUENCE OF:
b. Hypertensive Atherosclerotic
DUE TO OR AS A CONSEQUENCE OF:
c. Coronary Artery Disease
DUE TO OR AS A CONSEQUENCE OF:
d.

Approximate Interval Between Onset and Death

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

27. WAS DECEDENT PREGNANT OR IN 90 DAYS POSTPARTUM? (Yes or No): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Pakorn Tara MD
29c. MEDICAL LICENSE NO: 01031666
29d. DATE SIGNED (Month, Day, Year): 2/11/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): PAKORN TARA, M. D. 1101 E. GLENDALE BLVD. VALPARAISO, INDIANA 46383

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Gary S. Babiske MD
32. DATE FILED (Month, Day, Year): February 13, 1997

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.