

3

STATE OF INDIANA
LAKE COUNTY
FILED

2000 052757

2000 JUL 26 AM 10:19

MORTIS W. CENTER
LONDON

F31975

Property Address: 6407 Forest Avenue, Hammond, IN 46324
(See Attached Legal)

SURVIVORSHIP AFFIDAVIT

Kenneth P. Jones, Affiant, state that:

1. Bernice W. Jones, deceased, died on August 4, 1999.
2. Affiant is: the sole surviving trustee and husband.

Kenneth P. Jones

 Kenneth P. Jones as Trustee under Tr Dtd 07/28/96

Subscribed and sworn to before me, this 17th day of July, 2000.

Beth A. Kolbert

 Beth A. Kolbert, Notary Public



FILED

JUL 26 2000

BETH A. KOLBERT
 NOTARY PUBLIC STATE OF INDIANA
 Resident of Lake County
 My Commission Expires July 11, 2001

PETER BENJAMIN
 LAKE COUNTY AUDITOR

Prepared by: Kenneth P. Jones

HOLD FOR FIRST AMERICAN TITLE

13.00
AC

1512

25 x 17

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMMOND HEALTH DEPARTMENT.

Local No. 618

Aug. 24, 1999
St. Date Issued Franklin J. Remede
Hammond Health Commission

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) Bernice W. Jones		2 SEX Female	3a TIME OF DEATH 400 p M	3b DATE OF DEATH (Month Day Yr) August 4, 1999	
4 *SOCIAL SECURITY NUMBER 355-16-7431	5a AGE—Last Birthday (Years) 76	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) May 13, 1923	
7 BIRTHPLACE (City and State or Foreign Country) Eminence, Mo.	8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES? None	9a PLACE OF DEATH (Check only one—See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution give street and number) 6407 Forest		9c CITY TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Kenneth P. Jones	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife	12b KIND OF BUSINESS/INDUSTRY Home		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond	13d STREET AND NUMBER 6407 Forest		
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 10 College (1-4 or 5+) none		18 FATHER'S NAME (First Middle Last) Edson Griggs			
19 MOTHER'S NAME (First Middle Maiden Surname) Ola Stoddell		20a INFORMANT'S NAME (Type/Print) Kenneth Jones			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 Forest Hammond, In. 46324		20c Relationship Husband			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) August 6, 1999 Anatomical Gift Assoc. of Ill., Chicago, Ill.		21c LOCATION—City or Town, State	
22a EMBALMER'S NAME NONE		22b EMBALMER'S LICENSE NO. N/A	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) Fd 0109406	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Lahayne Fh 19400005 6955 SOUTHEASTERN Hammond, In 46324		
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. ADENOCARCINOMA OF BLON WITH HEPATIC METASTASIS AND LIVER FAILURE				Approximate Interval Between Onset and Death 2 months	
26 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) 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) no		
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) and manner as stated					
29b SIGNATURE AND TITLE OF CERTIFIER 			29c MEDICAL LICENSE NO. 01031582	29d DATE SIGNED (Month Day Year) 8-5-99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) LYLE R. MUNN MD 4321 FIR ST E. CHICAGO IN (August)					
31 HEALTH OFFICER'S SIGNATURE Franklin J. Remede M.D. #6312			32 DATE FILED (Month Day Year) August 5, 1999		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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
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			

**FIRST AMERICAN TITLE INSURANCE COMPANY
1544 45TH STREET, MUNSTER, IN 46321,**

**ALTA Commitment
Schedule C**

File No.: F31975

LEGAL DESCRIPTION:

Lots 32, 33 and 34 in Block 8 in Kenwood Addition to Hammond, as per plat thereof, recorded in Plat Book 10, page 17, in the Office of the Recorder of Lake County, Indiana.

