



TICOR TITLE INSURANCE

2000 056644

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Eva Overturf, being first duly sworn upon oath, deposes and says:

1. That Evan H. Overturf died on June 10, 1996 at Crown Point, Indiana

2. That Evan H. Overturf and Eva Overturf were duly and legally married at the time they acquired title as husband and wife to the following described real estate: entireties tenants by the

NOT OFFICIAL!
See Attached for Legal Description
This Document is the property of
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the Lake County Recorder!

- 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 were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Eva Overturf
Eva Overturf

Subscribed and sworn to before me, a Notary Public, this 4th day of August, 2000, 19/11.

Karen Kane
Karen Kane Notary Public

My Commission expires:

9-12-07

County of Residence:

Porter

This Instrument prepared by Eva Overturf



00570

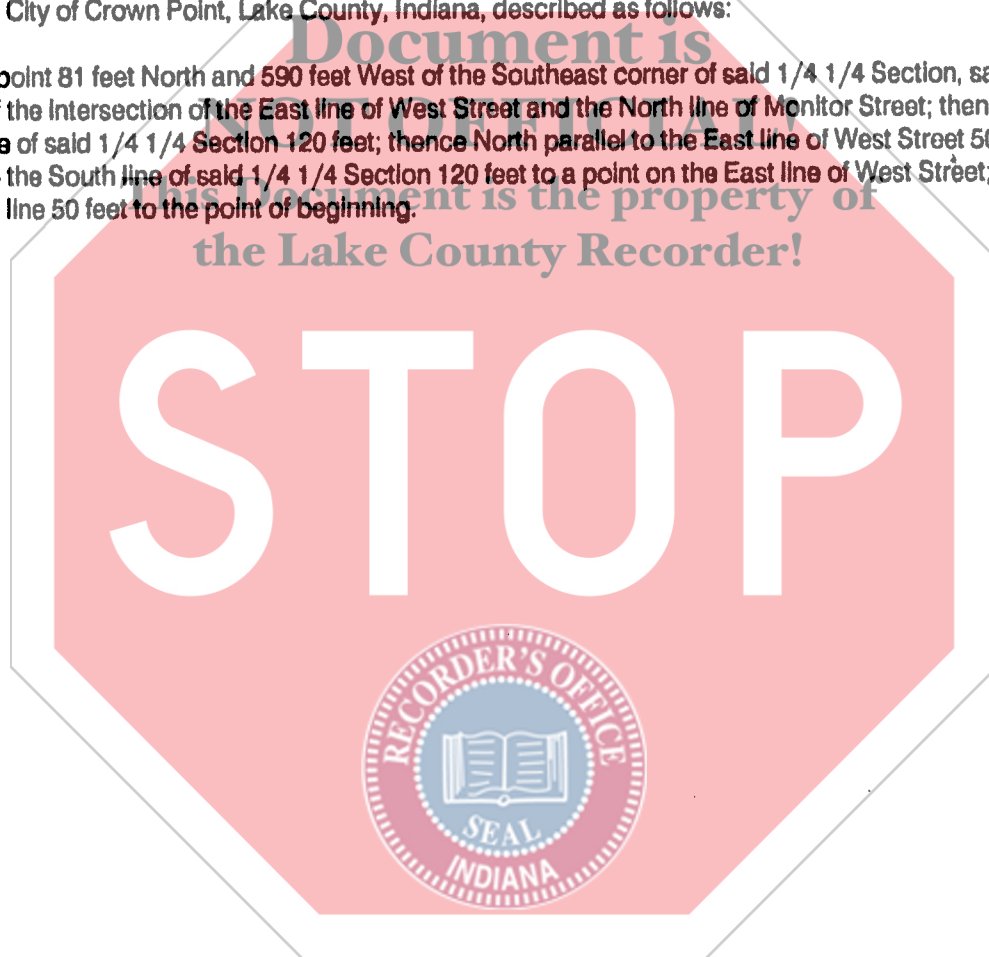
1300
Ac

T.L.

LEGAL DESCRIPTION

Part of the Northeast 1/4 of the Southwest 1/4 of Section 5, Township 34 North, Range 8 West of the 2nd Principal Meridian, in the City of Crown Point, Lake County, Indiana, described as follows:

Beginning at a point 81 feet North and 590 feet West of the Southeast corner of said 1/4 1/4 Section, said point being 48 feet North of the intersection of the East line of West Street and the North line of Monitor Street; thence East parallel to the South line of said 1/4 1/4 Section 120 feet; thence North parallel to the East line of West Street 50 feet; thence West parallel to the South line of said 1/4 1/4 Section 120 feet to a point on the East line of West Street; thence South along said East line 50 feet to the point of beginning.



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

State No.

Local No. 2107-96

40809
TYPE/PRINT
IN
PERMANENT
BLACK INK

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

| | | | | | | |
|---|--|---|--|---|---|---|
| 1. DECEASED—NAME (First, Middle, Last) EVAN H OVERTURF | | | | 2. SEX MALE | 3a. TIME OF DEATH 12:51 A | 3b. DATE OF DEATH (Month, Day, Yr) JUNE 10, 1996 |
| 4. SOCIAL SECURITY NUMBER 342-14-6854 | 5a. AGE—Last Birthday (Years) 75 | 5b. UNDER 1 YEAR Months Days | 5c. UNDER 1 DAY Hours Minutes | 6. DATE OF BIRTH (Mo, Day, Yr) Aug. 24, 1920 | 7. BIRTHPLACE (City and State or Foreign Country) Buckner, Illinois | |
| 8a. WAS DECEDENT A U.S. VETERAN? Yes | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945 | 9. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. ANTHONY MEDICAL CENTER | | | 9b. CITY, TOWN, OR LOCATION OF DEATH CROWN POINT | | 9c. COUNTY OF DEATH LAKE | |
| 10. MARITAL STATUS MARRIED | 11. SURVIVING SPOUSE (If wife, give maiden name) Eva M. Smith | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Salesman | | | 12b. KIND OF BUSINESS/INDUSTRY Root Lumber Co. | |
| 13a. RESIDENCE—STATE INDIANA | 13b. COUNTY LAKE | 13c. CITY, TOWN, OR LOCATION CROWN POINT | | 13d. STREET AND NUMBER 618 N. WEST STREET | | |
| 13e. ZIP CODE 46307 | 13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14. CITIZEN OF WHAT COUNTRY? U.S.A. | 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) 12 | | | | | | |
| 18. FATHER'S NAME (First, Middle, Last) NOBLE OVERTURF | | | 19. MOTHER'S NAME (First, Middle, Maiden Surname) NANNIE SMITH | | | |
| 20a. INFORMANT'S NAME (Type/Print) EVA M. OVERTURF | | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 N. WEST STREET, CROWN POINT, IN 46307 | | | 20c. Relationship WIFE | |
| 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) June 13, 1996 Chapel Lawn Memorial Gardens | | | 21c. LOCATION—City or Town, State Schererville Indiana | |
| 22a. EMBALMER'S NAME Russell Kraft Jr. | | 22b. EMBALMER'S LICENSE NO. 29300105 | | 23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i> | | 24b. LICENSE NUMBER (of Licensee) 100946 | | 25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445 | | |
| 26. PART I: Enter the disease, 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. Sideroblastic Anemia | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) | | | | | | |
| CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last 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) 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) N/A | | |
| 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 <i>R S Drasz</i> | | | | 29c. MEDICAL LICENSE NO. 01031484 | | 29d. DATE SIGNED (Month, Day, Year) June 12, 1996 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Ray H. Drasz, 811 Merrillville Road, Merrillville, Indiana | | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i> | | | | | | |
| 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. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) | | 34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) JUN 12 1996 | | |
| 34g. DATE PRONOUNCED DEAD (Month, Day, Year) | | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. | | | | |

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER