2

(1)

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

#1200032830 LO

STATE OF Indiana } S. S.
COUNTY OF Lake

On this August 18 2000 (insert date) before me personally appeared Kenneth R. Harrison

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is Owner (state interest of affiant in the above premises as "owner," "son of owner," etc.);
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Dorothy M. Harrison and Kenneth R. Harrison;
4. Said Dorothy M. Harrison (fill in name of co-tenant who died) died on November 1, 1990;

leaving No will; (Insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:

Lot 30 in Block 4 Subdivision of Blocks 2, 3, 4 and 5 of Stafford and Truckle's Addition to Hammond as per plat thereof, recorded in Plat Book 5, Page 5, in the Office of the Recorder of Lake County, Indiana.

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent:

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:

);

8. Affiant's relationship to the deceased was Spouse

Signature: Kenneth R. Harrison

Address: 8544 Kennedy Ave
Highland In 46322

Subscribed and sworn to before me by the affiant this August 18 2000 (insert date)

Shirley R. Kasper
Notary Public

SHIRLEY R. KASPER
Notary Public, State of Indiana
County of Lake
My Commission Expires Jul 31, 2008
01811

My Commission Expires 7-31-08

This instrument prepared by Kenneth R. Harrison

FILED

AUG 23 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2000 AUG 24 AM 9:48
RECORDER

2000 061415

Chicago Title Insurance Company

1

C.T. 12.00 AC

Local No. 936

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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

Nov. 2, 1990 — Date Issued — Franklin D. Pemudaa M.D., Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Dorothy M. Harrier	Female	8:15 a.m.	November 1, 1990

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 (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
329-09-2765	72			December 24, 1917	Westville, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
No	N/A	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Margaret Hospital	Hammond	Lake

10. MARITAL STATUS (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	Kenneth Harrier	homemaker	at Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hammond	4850 Pine

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46327	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Paul Klaman	Blanche Campbell

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Kenneth Harrier	4850 Pine Hammond, Indiana 46327	Husband

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)	NW Indiana Cremation Service, November 3, 1990	Crown Point, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
N/A	N/A	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Rod A. Jug	FD01018769	C.J. Huber Funeral Home FD-B002851, 722 165th Street Hammond, Indiana 46324

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.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Ventricular Stand Still — Cardiac Arrest — 10 min
DUE TO (OR AS A CONSEQUENCE OF)
b. Ventricular tachycardia — 1 hour
DUE TO (OR AS A CONSEQUENCE OF)
c. Coronary Insufficiency — 5 YEARS
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
e.

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I
Diabetes Mellitis, Congestive Heart Failure, Cerebral Vascular thrombosis

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
E. M. Alt MD	18725	Nov. 11/2/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
E. M. ALT MD 7550 Hohman, Munster, Ind 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Franklin D. Pemudaa M.D.	NOV 02 1990

CORONER 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

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.