

Chicago Title Insurance Company

3

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 062137

2000 AUG 28 AM 9:53

Chicago Title Insurance Company 620003099

SURVIVORSHIP AFFIDAVIT

On this 8-2-00 before me personally appeared
(Insert date)

Walker Tigner

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 SON OF 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
Fetnah Tigner and

4. Said Fetnah Tigner
(fill in name of co-tenant who died)

died on 11-6-99

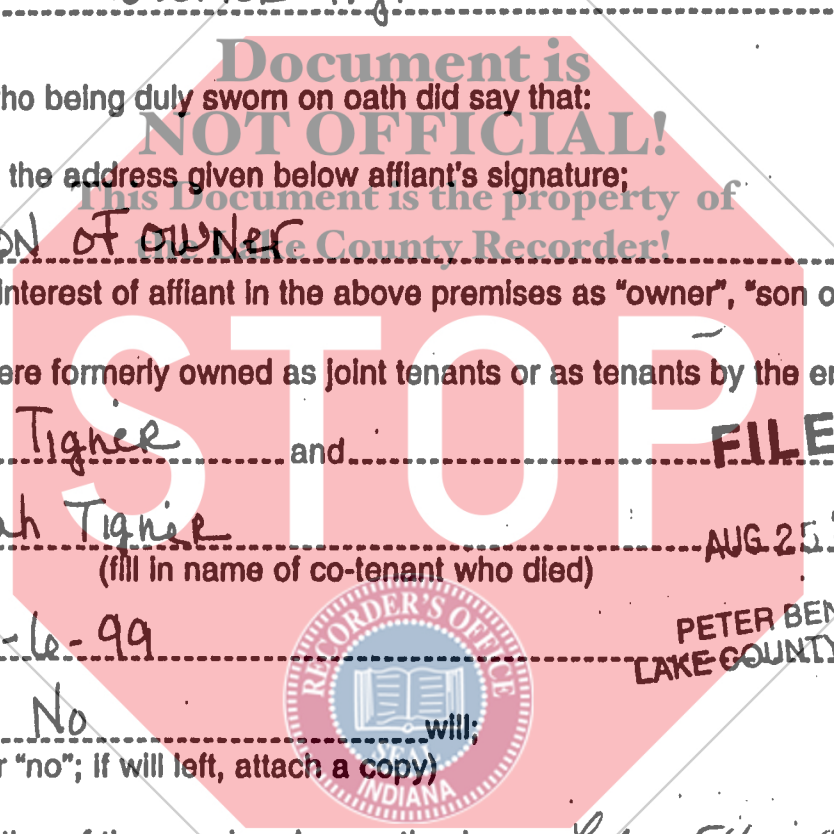
leaving No will;
(Insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is: lots 54 + 55
in Block 4, Jogg + Hammond's Second Addition
to the City of Hammond, as per plat thereof
recorded in Plat Book 2, page 8 in Lake County,
Indiana Reg No. 26-33-89-56

6. Is there Federal Estate or State inheritance tax liability by reason of the death of said
decendent? Yes No

If yes, then estimated taxes due are \$ _____

The taxes due are paid or unpaid.



01976

13.00
AC

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

.....

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

.....);

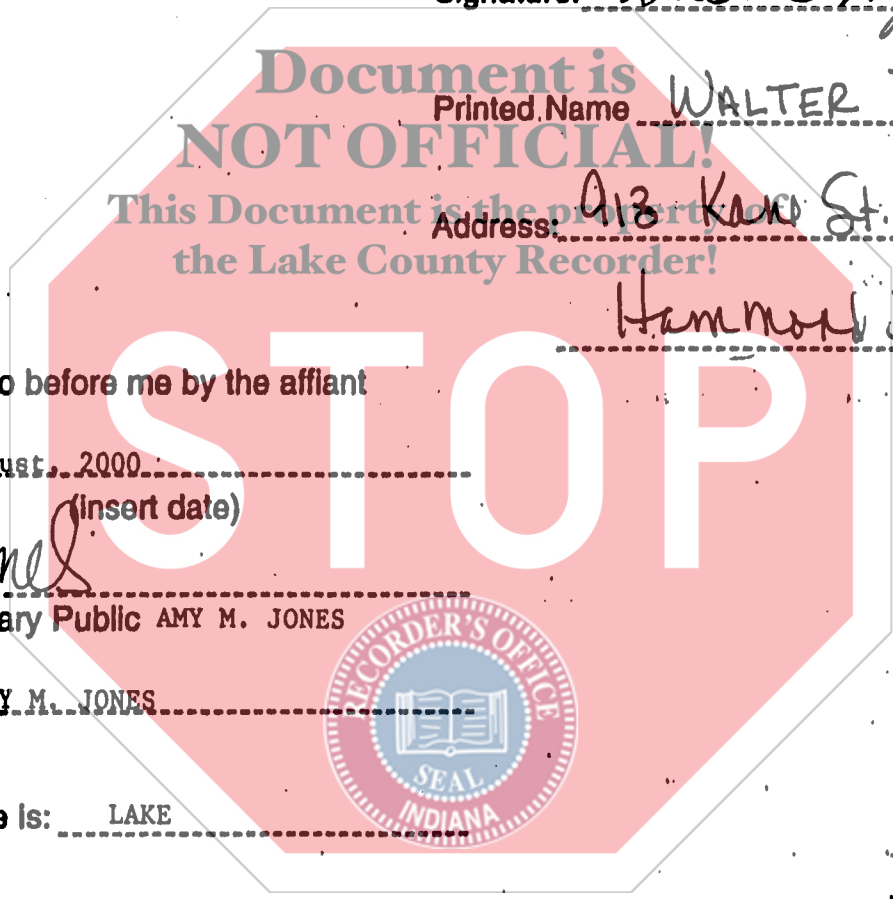
8. Affiant's relationship to the deceased was SON

Signature: Walter Tigner

Printed Name WALTER TIGNER

Address: 913 Kew St.

Hammond In 46320



Subscribed and sworn to before me by the affiant

this 8th day of August, 2000

(Insert date)

Amy M. Jones

Notary Public AMY M. JONES

Printed Name AMY M. JONES

My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires MAY 7, 2008

This instrument prepared by KATHERINE E. ADAMS

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

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

CERTIFICATE OF DEATH

State IN Date Issued Nov 12, 1999 [Signature] Hammond Health Commissioner

Local No. 888

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

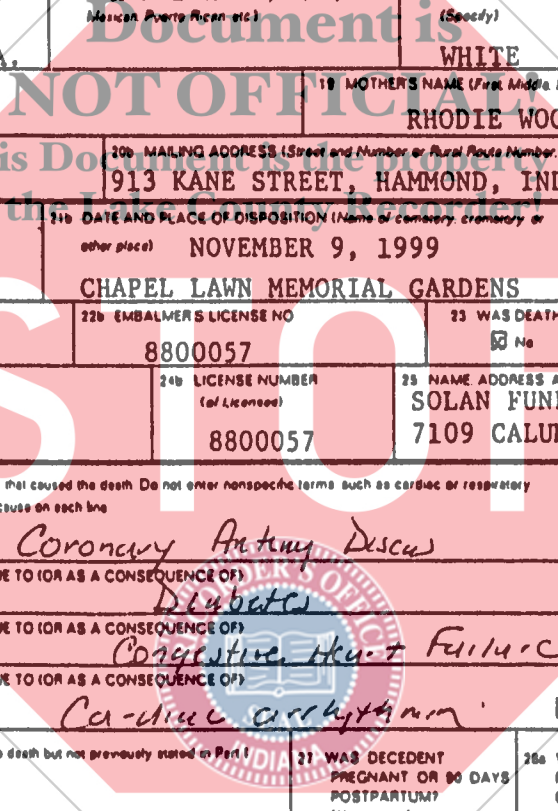
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) FETNAH P. TIGNER		2 SEX FEMALE	3a TIME OF DEATH 6:50 A.M.	3b DATE OF DEATH (Month Day Yr) NOVEMBER 6, 1999
4 SOCIAL SECURITY NUMBER 421-22-6938	5a AGE—Last Birthday (Year) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) OCTOBER 11, 1926
7 BIRTHPLACE (City and State or Foreign Country) JASPER, ALABAMA	8a WAS DECEDENT A US VETERAN? NO			
8b YEAR LAST SERVED IN US ARMED FORCES? N/A	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a FACILITY NAME (If not inpatient, give street and number) 913 KANE STREET		9b CITY, TOWN OR LOCATION OF DEATH HAMMOND		9c COUNTY OF DEATH LAKE
10 MARITAL STATUS (Specify) WIDOW	11 SURVIVING SPOUSE (If wife, give maiden name) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b KIND OF BUSINESS/INDUSTRY OWN HOME
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION HAMMOND	13d STREET AND NUMBER 913 KANE STREET	
14 ZIP CODE 46320	15 INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	16 CITIZEN OF WHAT COUNTRY? U.S.A.	17 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	18 RACE—American Indian, Black, White, etc (Specify) WHITE
19 DECEDENT'S EDUCATION (Specify only highest grade completed) 8TH		17 DECEDENT'S EDUCATION (Elementary/Secondary 10-12) College (1-4 or 5+)		
18 FATHER'S NAME (First Middle Last) PAUL STEED		19 MOTHER'S NAME (First Middle Maiden Surname) RHODIE WOODS		
20a INFORMANT'S NAME (Type/Print) WALTER L. TIGNER		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State Zip Code) 913 KANE STREET, HAMMOND, INDIANA 46320		20c Relationship SON
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) NOVEMBER 9, 1999 CHAPEL LAWN MEMORIAL GARDENS		21c LOCATION—City or Town, State SCHERERVILLE, INDIANA
22a EMBALMER'S NAME DEAN G. WAGNER		22b EMBALMER'S LICENSE NO. 8800057	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24 SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licenses) 8800057	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME SOLAN FUNERAL HOME FH83002893 7109 CALUMET AVE., HAMMOND, IN. 46324	
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. Coronary Artery Disease Diabetes Congestive Heart Failure Cardiac arrhythmia		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		
28 IMMEDIATE CAUSE (Final disease or condition resulting in death)		28a WAS AN AUTOPSY PERFORMED? (Yes or no) NO		
29 CONDITIONS if any which gave rise to the immediate cause, stating the underlying cause last		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I		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>Cheryl Worix - M.D.</i>		29c MEDICAL LICENSE NO. 01048405	29d DATE SIGNED (Month Day Year) November 9, 1999	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) CHERYL WORIX, M.D., 3229 BROADWAY AVE., GARY, INDIANA 46409 219-884-8400				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Serna M.D.</i>				32 DATE FILED (Month Day Year) November 12, 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 PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e DESCRIBE HOW INJURY OCCURRED		
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.		00016		



FILED

JUL 13 2000

**PETER BENJAMIN
LAKE COUNTY AUDITOR**

CASH AM 9.00