STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

3

2000 062137

2000 AUG 28 AM 9:53

MORRIS W. CARTER

Chicago Title Insurance Company 620003099

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

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

Walter 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 died on 11-6-99
(fill in name of co-tenant who died)
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, Hogg & Hammond's Second Addition to the City of Hammond, as per plat thereof recorded in Plat Book 2, page 8 in Lake County, Indiana Key No. 26-33-89-56
6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☑ No

If yes, then estimated taxes due are $.

The taxes due are ☐ paid or ☐ unpaid.

FILED

AUG 25 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

01976

13.00 PC

7. Where this affidavit relates to a tenancy by the entireties, 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: 413 Kane 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.

Local No. 888

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Stat Nov. 12, 1999 Date Issued — Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

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 (Years): 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 U S VETERAN? NO
8b YEAR LAST SERVED IN US ARMED FORCES? N/A
9a PLACE OF DEATH (Check only one See instructions): ☐ HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b FACILITY NAME (If not institution, give street and number): 913 KANE STREET
9c CITY, TOWN OR LOCATION OF DEATH: HAMMOND
9d 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
13e ZIP CODE: 46320
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY? U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 8TH; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): PAUL STEED
19 MOTHER'S NAME (First, Middle, Maiden Surname): RHODIE WOODS

INFORMANT

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

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ 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? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Dean G. Wagner
24b LICENSE NUMBER (of Licensee): 8800057
25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH83002893, 7109 CALUMET AVE., HAMMOND, IN. 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

FILED JUL 13 2000 PETER BENJAMIN LAKE COUNTY AUDITOR

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
b. Diabetes
DUE TO (OR AS A CONSEQUENCE OF):
c. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
d. Cardiac arrhythmia

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

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

CERTIFIER

29a CERTIFIER (Check only one):
☒ 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: Cheryl A Worix - Worix M.D
29c MEDICAL LICENSE NO: 010418405
29d DATE SIGNED (Month Day Year): November 9, 1999

HEALTH OFFICER

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: Franklin J. Grenuda M.D.
32 DATE FILED (Month Day Year): November 12, 1999

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

00016

SDH06-004 State Form 10110 (R5/1-99)

CASH AM 9.00