(3)

FA# **06024007**
LEGAL DESCRIPTION:
Lot 14 in Block 2 in Hammond Steel City Addition to the City of Hammond, as per plat thereof, recorded in Plat Book 17, page 18, in the Office of the Recorder of Lake County, Indiana.

First American Title Insurance Company

PROPERTY ADDRESS:
3922 Torrence Blvd., Hammond, IN 46327

2002 002404

ESTATE AFFIDAVIT

Frances L. Ross, Affiant, states that:

1. **Frank S. Ross**, deceased, died on the 6 day December of 2000;
2. Affiant is: [X] the surviving spouse of the deceased,
   [ ] the Personal Representative/Executor-trix of the estate of the deceased;
3. The deceased died: [X] leaving a will which has been probated;
   [ ] leaving a will which has not been probated;
   [ ] leaving no will;
4. The deceased and Affiant were married on the day of 1937; and were never divorced. (This item applies only to the surviving spouse.)
5. [X] All expenses of the last illness and funeral of the deceased have been paid;
6. [X] All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;
7. [X] There have been no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

1/3/02
Date

Frances L. Ross by Robert Ross (POA)
Signature of Affiant

By: Robert Ross, as atty-in-fact
Printed Name of Affiant

State of Indiana, County of **LAKE**

Subscribed and sworn to before me, this **3RD** day of **JANUARY**, **2002**.

JENNIFER C. ARCUS
Printed Name of Notary

Signature of Notary

My Commission expires: **11-15-09**

My County of Residence is: **LAKE**

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2002 JAN -8 AM 10:15
MORRIS W. CARTER
RECORDER

FILED
JAN 8 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

THIS INSTRUMENT WAS PREPARED BY: **ROBERT ROSS**

000378

* **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. 977

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

DEC. 8, 2000 Date Issued — Hammond Health Commission

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

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.)
Frank	S.	Ross	Male	4:10 A M	December 6, 2000

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)
325-12-0354	91					OCTOBER 16, 1909	CHICAGO, 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)
YES	1932	HOSPITAL ☒ 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 MERCY 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	FRANCES L. BISCHOFF	PRESSMAN	PRINTING COMPANY

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	3922 TORRENCE AVENUE

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)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46327	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	8	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
MICHAEL ROSS	ROSE NEMIC

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
FRANCES L. ROSS	3922 TORRENCE AVENUE, HAMMOND, IN 46327	WIFE

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 ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	DECEMBER 11, 2000 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
KEITH D. ANTHONY	01011911	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Keith D Anthony	01011911	ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, IN 46327

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a Metabolic Acidosis

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
b DUE TO (OR AS A CONSEQUENCE OF) Renal Failure
c DUE TO (OR AS A CONSEQUENCE OF)
d DUE TO (OR AS A CONSEQUENCE OF)

Approximate Interval Between Onset and Death: Days / Months

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)	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)
☒ 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)
MD	0152530A	DEC. 6, 2000

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Erik DeLue MD St. Margaret Mercy Hospital 5454 HOHMAN AVENUE, HAMMOND, IN 46320

31 HEALTH OFFICER'S SIGNATURE Franklin D. Bermuda M.D.

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED	32 DATE FILED (Month Day Year)
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide					December 8, 2000

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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

06024007

This certified copy is given free of charge pursuant to law on the condition it will be used solely for Veterans benefits and or to determine eligibility for Veterans benefits.

Franklin D. Grenda M.D.
Hammond Health Commissioner
Hammond, Indiana

060240007