

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.



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

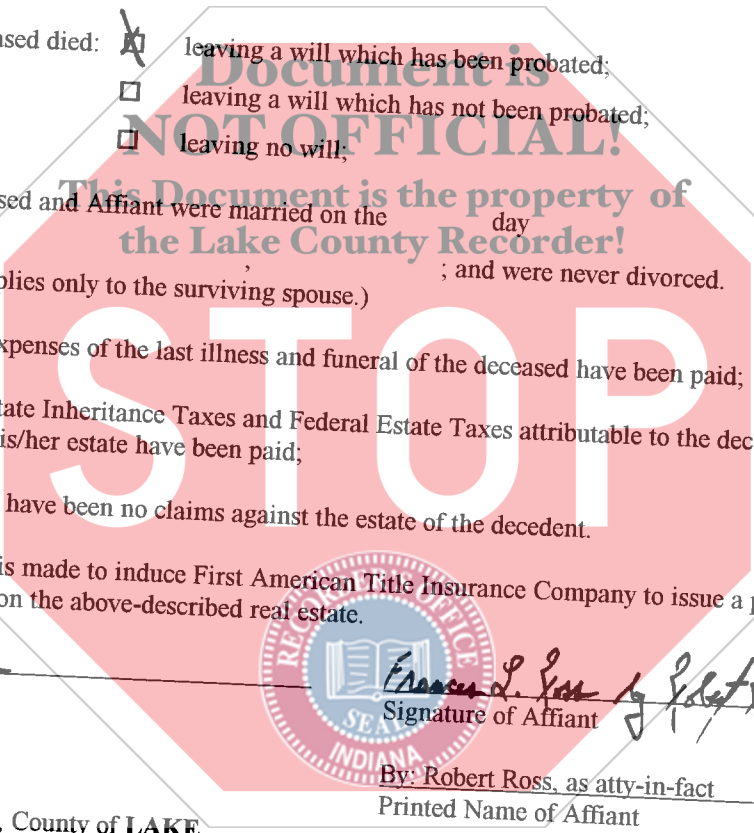
ESTATE AFFIDAVIT

Frances L. Ross, Affiant, states that:

1. Frank S. Ross, deceased, died on the 6 day December of 2000;
2. Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the estate of the deceased;
3. The deceased died: 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. All expenses of the last illness and funeral of the deceased have been paid;
6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;
7. There have been no claims against the estate of the decedent.

2002 002404

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



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

Date 1/3/02
Signature of Affiant Frances L. Ross by Robert S. Ross (POA)

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

Jennifer C. Arcus
Signature of Notary

FILED

My Commission expires: 11-15-09

JAN 8 2002

My County of Residence is: LAKE

PETER BENJAMIN
LAKE COUNTY AUDITOR

THIS INSTRUMENT WAS PREPARED BY: ROBERT ROSS

000378

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06024007

HOLD FOR FIRST AMERICAN TITLE

14 02
FA
FA

* 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

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

Local No. 977

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

DEC 8 2000
Date Issued
Frank J. Premuda
Hammond Health Commissioner

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

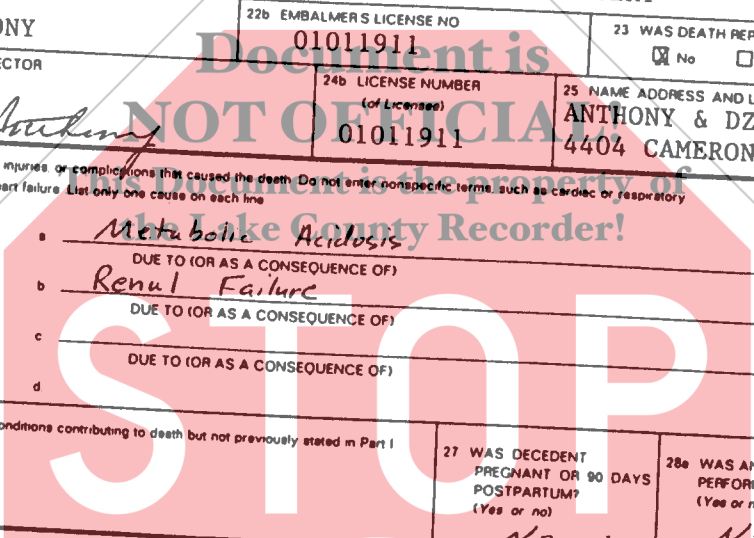
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Frank S. Ross		2 SEX Male		3a TIME OF DEATH 4:10 A M		3b DATE OF DEATH (Month, Day, Yr) December 6, 2000	
4 *SOCIAL SECURITY NUMBER 325-12-0354		5a AGE—Last Birthday (Years) 91		5b UNDER 1 YEAR Months: _____ Days: _____		5c UNDER 1 DAY Hours: _____ Minutes: _____	
6a WAS DECEDENT A U.S. VETERAN? YES		6b YEAR LAST SERVED IN U.S. ARMED FORCES? 1932		8 DATE OF BIRTH (Mo, Day, Yr) OCTOBER 16, 1909		7 BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS	
9a 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			
9b FACILITY NAME (If not institution, give street and number) ST. MARGARET MERCY HOSPITAL				9c CITY, TOWN OR LOCATION OF DEATH HAMMOND		9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) FRANCES L. BISCHOFF		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) PRESSMAN		12b KIND OF BUSINESS/INDUSTRY PRINTING COMPANY	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION HAMMOND		13d STREET AND NUMBER 3922 TORRENCE AVENUE	
13e ZIP CODE 46327		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		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) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____		18 FATHER'S NAME (First, Middle, Last) MICHAEL ROSS			
19 MOTHER'S NAME (First, Middle, Maiden Surname) ROSE NEMIC				20a INFORMANT'S NAME (Type/Print) FRANCES L. ROSS			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3922 TORRENCE AVENUE, HAMMOND, IN 46327				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) DECEMBER 11, 2000 HOLY CROSS CEMETERY		21c LOCATION—City or Town, State CALUMET CITY, ILLINOIS			
22a EMBALMER'S NAME KEITH D. ANTHONY		22b EMBALMER'S LICENSE NO. 01011911		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b LICENSE NUMBER (of Licensee) 01011911		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, IN 46327			
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 <u>Metabolic Acidosis</u>				Approximate Interval Between Onset and Death Days	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b <u>Renal Failure</u>				Months	
		c _____					
		d _____					
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) No			
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) as stated.							
29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		29c MEDICAL LICENSE NO. 0152530A		29d DATE SIGNED (Month, Day, Year) DEC 6 2000			
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 <i>Franklin J. Premuda M.D.</i>							
32 DATE FILED (Month, Day, Year) December 8, 2000		33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					
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.					



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 J. Premuda M.D.
Hammond Health Commissioner
Hammond, Indiana



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