

2002 007156

AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Mae Frances Cattledge, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Howard D. Cattledge died (without leaving a will) (leaving a will) on September 16, 19 98 at The Community Hospital, Munster, Indiana

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

THE EAST 35 FEET OF LOT 7 IN BLOCK 2 IN MARBLE'S SUBDIVISION OF BLOCKS 3, 4, 5 AND 6 OF MARBLE'S ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 2 PAGE 5, IN THE THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Document is NOT VALID if the Recorder of the Lake County Recorder!

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (~~her~~) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

**FILED**

JAN 17 2002

Mae Frances Cattledge  
Mae Frances Cattledge  
PETER BENJAMIN  
LAKE COUNTY AUDITOR

Subscribed and sworn to before me, a Notary Public, this 11th day of January, 19 2002.

Prepared by Patrick J. McManama, Attorney at Law, Identification#9534-45  
Cynthia M. Washburn  
Notary Public

COMMUNITY TITLE COMPANY  
FILE NO 22732

CYNTHIA M. WASHBURN  
NOTARY PUBLIC, STATE OF INDIANA  
COUNTY OF LAKE  
MY COMMISSION EXPIRES OCT. 31, 2008

001103

11/03/02  
CM

10cc

\* 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

State No. ....

Local No. 2106-98

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

26458  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>HOWARD CATTLEGE</b>				2. SEX <b>MALE</b>		3a. TIME OF DEATH <b>9:15 AM</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>SEPTEMBER 16, 1998</b>			
4. *SOCIAL SECURITY NUMBER <b>326-30-9535</b>		5a. AGE—Last Birthday (Year) <b>62</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) <b>December 25, 1935</b>			
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		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					7. BIRTHPLACE (City and State or Foreign Country) <b>Houston, Mississippi</b>		
9b. FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>			9d. COUNTY OF DEATH <b>LAKE</b>				
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Frances Childress</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)			12b. KIND OF BUSINESS/INDUSTRY				
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Hammond</b>			13d. STREET AND NUMBER <b>1003 Fields Street</b>				
13e. ZIP CODE <b>46320</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) <b>Afro-American</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5 +)	
18. FATHER'S NAME (First, Middle, Last) <b>Tommy Cattledge</b>					19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gerlean Reed</b>						
20a. INFORMANT'S NAME (Type/Print) <b>Frances Cattledge</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1003 Fields Street Hammond, IN 46320</b>				20c. Relationship <b>Wife</b>			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>September 22, 1998 Oak Hill Cemetery</b>				21c. LOCATION—City or Town, State <b>Gary, Indiana</b>			
22a. EMBALMER'S NAME <b>Sherman Banks</b>				22b. EMBALMER'S LICENSE NO. <b>FDO 1016254</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Sherman Banks</i>				24b. LICENSE NUMBER (of Licensee) <b>FDO 1016254</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Smith Bizzell &amp; Warner Funeral Home 4209 Grant Street Gary, IN 46408 FH19600034</b>					
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. <b>STROKE caused by stroke &amp; clots</b> DUE TO (OR AS A CONSEQUENCE OF) <b>valve and clots</b>										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)											
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)					28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)				
29. 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>Daniel J. Smith</i>						29c. MEDICAL LICENSE NO. <b>01031674</b>		29d. DATE SIGNED (Month, Day, Year) <b>SEPTEMBER 22, 1998</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DANIEL J. SMITH, M.D. 761 45TH STREET MUNSTER, INDIANA 46321</b>											
31. HEALTH OFFICER'S SIGNATURE <i>Alexander H. ... MD</i>								32. DATE FILED (Month, Day, Year) <b>September 23, 1998</b>			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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.							

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