

STATE OF INDIANA)
)
COUNTY OF ~~XXXX~~ PORTER)

SS:

2002 007860

2002 JAN 16 10:01

AFFIDAVIT OF HEIRSHIP AND DEATH

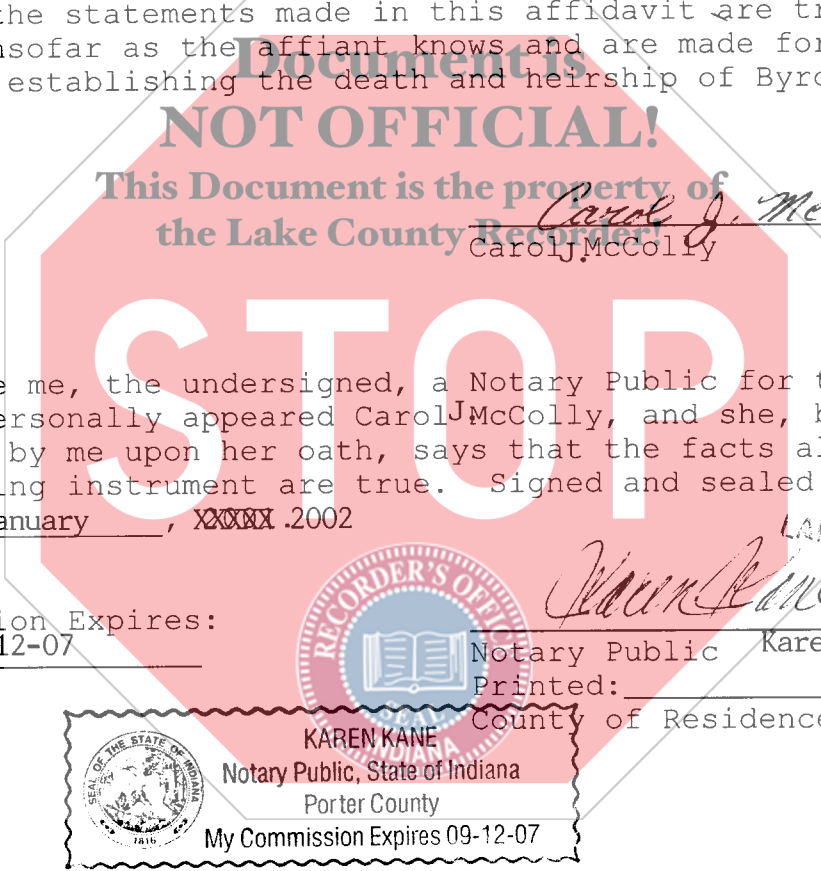
Comes now Carol^J McColly, being first duly sworn, upon her oath, and states as follows:

That she is the surviving spouse of the decedent, Byron E. McColly, who died intestate a resident of Hendricks County, Indiana, on the 25th day of May 1993, as demonstrated by the Certificate of Death attached hereto as Exhibit "A" and incorporated herein by reference.

That to the best of affiant's knowledge, said Byron E. McColly left surviving him the following heirs at law: 1) Carol McColly, his surviving spouse and 2) Christy L. Krathwohl, his daughter. Said decedent left no other child or children, or descendants of any predeceased child or children, and all survivors are competent adults.

That the statements made in this affidavit are true and complete insofar as the affiant knows and are made for the purpose of establishing the death and heirship of Byron E. McColly.

5-26-5 + 5-27-1 (4)



Carol J. McColly

Carol J. McColly

FILED

Before me, the undersigned, a Notary Public for the State of Indiana, personally appeared Carol^J McColly, and she, being first duly sworn by me upon her oath, says that the facts alleged in the foregoing instrument are true. Signed and sealed this 16th day of January, ~~XXXX~~ 2002

**PETER BENJAMIN
LAKE COUNTY AUDITOR**

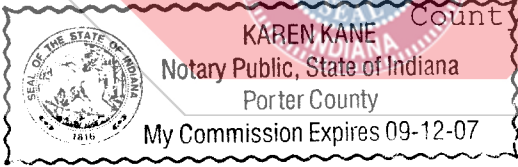
Karen Kane

Notary Public

My Commission Expires: 9-12-07

Printed: _____
County of Residence: Porter

(SEAL)



001420

Prepared By: Carol J. McColly

TICOR TITLE INSURANCE
Valparaiso, IN 46383
920016982

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13*

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

| | | | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|---|---|--|--|
| 1. DECEASED—NAME (First, Middle, Last) Byron Eugene McColly | | | | 2. SEX male | | 3a. TIME OF DEATH 8:13 P M | | 3b. DATE OF DEATH (Month, Day, Yr.) May 25, 1993 | | | | |
| 4. SOCIAL SECURITY NUMBER 317-36-8083 | | 5a. AGE—Last Birthday (Years) 57 | | 5c. UNDER 1 YEAR Months Days | | 5c. UNDER 1 DAY Hours Minutes | | 6. DATE OF BIRTH (Mo, Day, Yr.) May 20, 1936 | | 7. BIRTHPLACE (City and State or Foreign Country) Hebron, IN | | |
| 8a. WAS DECEDENT A U.S. VETERAN? NO | | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NA | | 9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" 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) Hendricks Community Hospital | | | | | | 9c. CITY, TOWN, OR LOCATION OF DEATH Danville | | | 9d. COUNTY OF DEATH Hendricks | | | |
| 10. MARITAL STATUS (Specify) married | | 11. SURVIVING SPOUSE (If wife, give maiden name) Carol Frailey | | | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Wood shop teacher | | | 12b. KIND OF BUSINESS/INDUSTRY IN Boys School | | | | |
| 13a. RESIDENCE—STATE Indiana | | 13b. COUNTY Hendricks | | 13c. CITY, TOWN, OR LOCATION Plainfield | | | 13d. STREET AND NUMBER 1741 Rachel Drive | | | | | |
| 13e. ZIP CODE 46168 | | 13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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): 12 College (1-4 or 5+): 0 | | |
| 18. FATHER'S NAME (First, Middle, Last) Irvin McColly | | | | | | 19. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Fitzgerald | | | | | | |
| 20a. INFORMANT'S NAME (Type/Print) Carol McColly | | | | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1741 Rachel Dr. Plainfield, IN 46168 | | | | 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) May 29, 1993 Maple Hill Cemetery | | | | 21c. LOCATION—City or Town, State Plainfield, IN | | | | |
| 22a. EMBALMER'S NAME Charles W. Baker | | | | 22b. EMBALMER'S LICENSE NO. FD 01013159 | | 23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | | | | | | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>Charles W. Baker</i> | | | | 24b. LICENSE NUMBER (of Licensee) FD01013159 | | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Hall-Baker Funeral Home-89200014 339 E. Main St. Plainfield, IN 46168 | | | | | | |
| 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. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) a. _____ b. _____ c. _____ d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| 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?) YES | | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) YES | | |
| 29a. CERTIFIER (Check only one) <input 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 checked="" 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>Steven S. Matthews</i> CORONER | | | | | | 29c. MEDICAL LICENSE NO. | | 29d. DATE SIGNED (Month, Day, Year) May 26, 1993 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Steven S. Matthews, Coroner Hendricks Co., 402 E. Main St. Brownsburg, IN 46112 | | | | | | | | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>Edward M. Elroy MD</i> | | | | | | | | | | 32. DATE FILED (Month, Day, Year) June 1, 1993 | | |
| 33. MANNER OF DEATH <input checked="" 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) May 25, 1993 | | | | 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. | | | | | | | | |

Exhibit "A"