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FA# 06027064

LEGAL DESCRIPTION:

Lot 37, Block 3, Evergreen Park, in the City of Hammond, as per plat thereof, recorded in Plat Book 28, page 81, in the Office of the Recorder of Lake County, Indiana.



First American Title Insurance Company

PROPERTY ADDRESS:

7546 Walnut Avenue, Hammond, IN 46324

ESTATE AFFIDAVIT

BILLIE HEADRICK

, Affiant, states that:

1. **ROBERT L. HEADRICK**, deceased, died on the 27 day of February, 1999;

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 2 day November of 1955; 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.

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

4-29-02
Date

Billie Headrick
Signature of Affiant

BILLIE HEADRICK Billie Headrick
Printed Name of Affiant

State of Indiana, County of LAKE

Subscribed and sworn to before me, this 29TH day of APRIL, 2002

CORINA CASTEL RAMOS
Printed Name of Notary

[Signature]
Signature of Notary

My Commission expires: 5-16-09

My County of Residence is: LAKE

FILED

MAY 01 2002

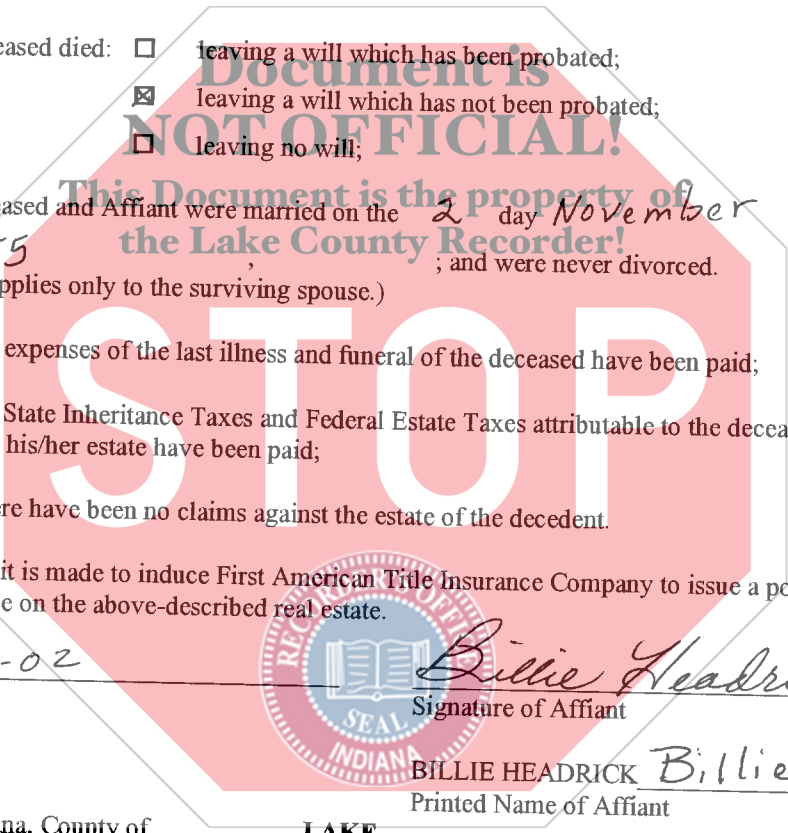
THIS INSTRUMENT WAS PREPARED BY: BILLIE HEADRICK

PETER BENJAMIN
LAKE COUNTY AUDITOR

HOLD FOR FIRST AMERICAN TITLE

06027064

12.00.00
FA



2002 040855
2002 APR 1 10:31

* 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. 044-99
303616
TYPE/PRINT
IN
PERMANENT
BLACK INK

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

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) ROBERT Larkin HEADRICK			2. SEX MALE	3a. TIME OF DEATH 6:05 P.M.	3b. DATE OF DEATH (Month, Day, Yr.) FEBRUARY 27, 1999
4. *SOCIAL SECURITY NUMBER 424-46-4758	5a. AGE—Last Birthday (Year) 39	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) April 1, 1939	7. BIRTHPLACE (City and State or Foreign Country) Mississippi
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	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) THE COMMUNITY HOSPITAL	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Billie Jean Hamilton	12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Driver		9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9d. COUNTY OF DEATH LAKE
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hammond		13d. STREET AND NUMBER 7546 Walnut Avenue	
13e. ZIP CODE 46324	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? U.S.A.	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. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) u/a College (1-4 or 5+)
18. FATHER'S NAME (First, Middle, Last) Robert S. Headrick			19. MOTHER'S NAME (First, Middle, Maiden-Surname) Thelma A. Powell		
20a. INFORMANT'S NAME (Type/Print) Mrs. Billie J. Headrick			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7546 Walnut Ave. Hammond, Indiana 46324		20c. Relationship Wife
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) March 3, 1999 Oakland Memory Lane Crematory		21c. LOCATION—City or Town, State Dolton, Illinois	
22a. EMBALMER'S NAME Jose G. Corona		22b. EMBALMER'S LICENSE NO. 08601373		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Jose G. Corona</i>		24b. LICENSE NUMBER (of Licensee) 08601373		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Ruzich Funeral Home #83020724 2031 Indianapolis Blvd. Whitefish, IN 46394	
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. SEPSIS a. _____ DUE TO (OR AS A CONSEQUENCE OF) _____ b. _____ DUE TO (OR AS A CONSEQUENCE OF) _____ c. _____ DUE TO (OR AS A CONSEQUENCE OF) _____ d. _____ IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last MAR 03 1999 <i>Alexander S. Williams, M.D.</i> LAKE COUNTY HEALTH COMMISSIONER					
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>Joseph A. DeJoni</i> M.D.				29c. MEDICAL LICENSE NO. 01046269	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) JOSEPH DEJONI, M.D., 7905 CALUMET AVENUE, MUNSTER, INDIANA 46321				29d. DATE SIGNED (Month, Day, Year) MARCH 2, 1999	
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>					
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 FILED
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) MAY 09 2002			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

PETER BENJAMIN
LAKE COUNTY AUDITOR