FA# **06026888**
LEGAL DESCRIPTION:
The South 71.5 feet of the North 143 feet of the South 330 feet of the East half of the West half of the East half of the Southwest quarter of the Southwest quarter of Section 9, Township 36 North, Range 9 West of the Second Principal Meridian, in Lake County, Indiana.

2002 047141

PROPERTY ADDRESS:
7246 Lindberg Ave, Hammond, IN 46323

ESTATE AFFIDAVIT

VIRGINIA LOVRICH, Affiant, states that:

1. TESSEY ROBERTS, deceased, died on the 28 day of JANUARY, 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 ——— day ~~Fr~~ 1957 of ———, ———; 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.

MAY 17, 2002
Date

Tessey Roberts by Virginia Lovrich [signature]
Signature of Affiant

Printed Name of Affiant

State of Indiana, County of LAKE

Subscribed and sworn to before me, this 17th day of MAY, 2002

CORINA CASTEL RAMOS
Printed Name of Notary

[signature]
Signature of Notary

My Commission expires: 5-16-09

My County of Residence is: LAKE

THIS INSTRUMENT WAS PREPARED BY: VIRGINIA LOVRICH

FILED
MAY 21 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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STOP

HOLD FOR FIRST AMERICAN TITLE 001674
6026888

12.00 M.Y. FA

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 43

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED–NAME (First Middle Last)	Tesney Harrison Roberts
2. SEX	Male
3a. TIME OF DEATH	9:33PM
3b. DATE OF DEATH (Month Day Yr)	January 28, 1999
4. SOCIAL SECURITY NUMBER	312-10-4412
5a. AGE - Last Birthday (Years)	90
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo Day Yr)	August 5, 1908
7. BIRTHPLACE (City and State or Foreign Country)	Double Springs, AL
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	St. Catherine Hospital
9c. CITY TOWN OR LOCATION OF DEATH	East Chicago
9d. COUNTY OF DEATH	Lake
10. MARITAL STATUS (Specify)	Married
11. SURVIVING SPOUSE (If wife, give maiden name)	Ruby E. Parks
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Carpenter
12b. KIND OF BUSINESS INDUSTRY	Construction
13a. RESIDENCE - STATE	Indiana
13b. COUNTY	Lake
13c. CITY TOWN OR LOCATION	Hammond
13d. STREET AND NUMBER	7246 Lindberg Avenue
13e. ZIP CODE	46323
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN?	[X] No [ ] 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)	06
College (1-4 or 5+)	

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Joseph Roberts
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Mary Hill

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Bettie Foraker
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	12109 Whistling Way, Bradenton, FL 34202
20c. Relationship	Daughter

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[ ] Burial [X] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	February 2, 1999 Regional Cremation Services
21c. LOCATION - City or Town State	Munster, Indiana
22a. EMBALMER'S NAME	James W. Gholston
22b. EMBALMER'S LICENSE NO.	FDE1004194
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	George J. Johnson (signature)
24b. LICENSE NUMBER (of Licensee)	FDE8900006
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME	FDE83002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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) / Conditions if any which gave rise to the immediate cause stating the underlying cause last	Cause	Approximate Interval Between Onset and Death
a.	Ventricular Fibrillation	
b. DUE TO (OR AS A CONSEQUENCE OF)	End Stage Cardiomyopathy	
c. DUE TO (OR AS A CONSEQUENCE OF)	Coronary artery disease	
d. DUE TO (OR AS A CONSEQUENCE OF)		

Field	Entry
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

CERTIFIER

29a. CERTIFIER (Check only one)

- [X] 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	R. Llobet (signature)
29c. MEDICAL LICENSE NO	01038128-1995
29d. DATE SIGNED (Month Day Year)	2-8-99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Dr. Ramon Llobet, 4320 Fir St., East Chicago, IN

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Dr. Timothy Raykovich (signature)
32. DATE FILED (Month Day Year)	2-8-99
33. MANNER OF DEATH	[X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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, 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.	

FILED
MAY 21 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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STOP
RECORDER'S OFFICE SEAL INDIANA

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1