

3

STATE OF INDIANA )

COUNTY OF Lake 2002 047292

2002 NOV 26

NOV 26 2002

Survivorship Affidavit

Fannie Kate Peterson being of legal age, and duly sworn upon his oath deposes and says:

FILED First American Equity Loan Services, Inc.  
Certification Number  
3085374

1. That Fannie Kate Peterson is the legal owner in fee simple title of the following described real estate located in Lake County, Indiana to-wit:

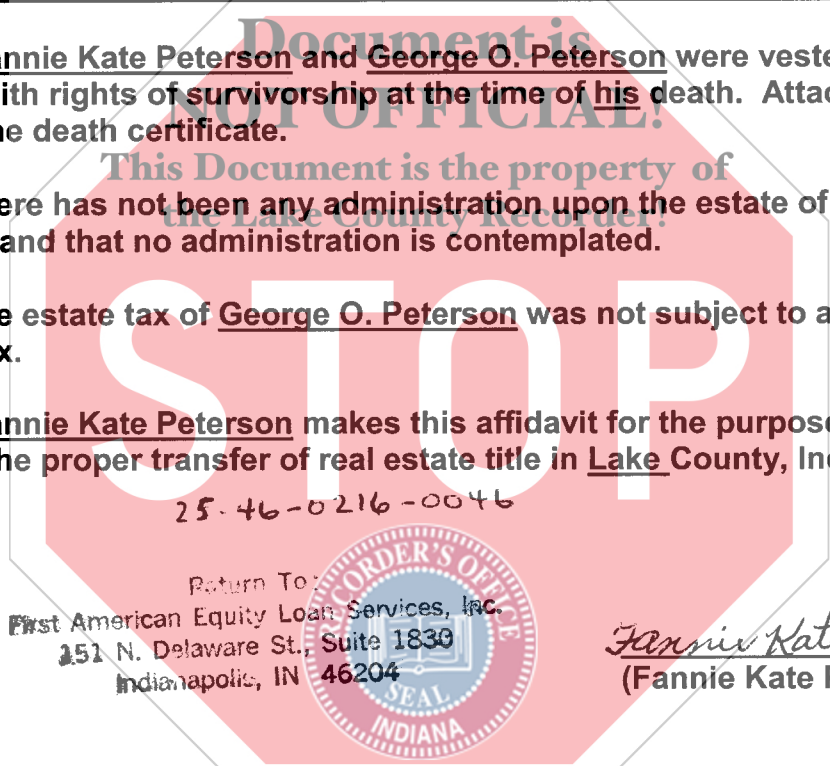
Legal: The North 8 feet of Lot 43, all of Lot 44 and the South 9 feet of Lot 45 in Block 61 in Chicago-Tolleston Land and Investment Company's Second Oak Park Addition to Tolleston, in the City of Gary, as per plat thereof, recorded in plat book 2, page 36, in the Office of the Recorder of Lake County, Indiana, except that part of said lot taken for alley purposes.

2. That Fannie Kate Peterson and George O. Peterson were vested as joint tenants with rights of survivorship at the time of his death. Attached is a copy of the death certificate.

3. That there has not been any administration upon the estate of George O. Peterson and that no administration is contemplated.

4. That the estate tax of George O. Peterson was not subject to any Federal Estate Tax.

5. That Fannie Kate Peterson makes this affidavit for the purpose of causing the proper transfer of real estate title in Lake County, Indiana.



**FILED**

MAY 21 2002

25-46-0216-0046

Return To:  
First American Equity Loan Services, Inc.  
151 N. Delaware St., Suite 1830  
Indianapolis, IN 46204



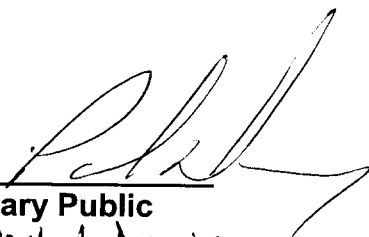
PETER BENJAMIN  
COUNTY AUDITOR  
*Fannie Kate Peterson*  
(Fannie Kate Peterson)

Subscribed and sworn before me, a Notary Public in and for County and State this day of 31 JANUARY

My commission expires: 7/13/09

002725  
13-  
N.H.  
FAE  
36616

This instrument was prepared by: Pam Bernard  
Home Equity Processor

  
Notary Public  
Paul A. Downing

Residing at:  
3981 Cleveland  
Gory IN



ATTENTION ESTATE: Disclosure of the facts we need to pursue our responsibilities voluntarily and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2770-94

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

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>George O. Peterson</b>				2. SEX <b>Male</b>		3a. TIME OF DEATH <b>12:00 p.m.</b>		3b. DATE OF DEATH (Month, Day, Year) <b>October 22, 1994</b>							
4. SOCIAL SECURITY NUMBER <b>412-36-9805</b>		5a. AGE—Last Birthday (Years) <b>74</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) <b>Feb. 21, 1920</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Stanton, Tennessee</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA 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) <b>Methodist Hospital Southlake Campus</b>				9c. CITY, TOWN OR LOCATION OF DEATH <b>Merrillville</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Fannie Kate Bowles</b>			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Janitor</b>				12b. KIND OF BUSINESS/INDUSTRY <b>Lake Machine &amp; Tool Work</b>						
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Gary</b>			13d. STREET AND NUMBER <b>2515 Jackson Street</b>								
13e. ZIP CODE <b>46407</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 checked="" 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 Amer</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5- )					
18. FATHER'S NAME (First, Middle, Last) <b>Billie Peterson</b>						19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence Bowman</b>									
20a. INFORMANT'S NAME (Type/Print) <b>Fannie Kate Peterson</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2515 Jackson Street Gary, Indiana 46407</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>October 29, 1994 Evergreen Memorial Park</b>				21c. LOCATION—City or Town, State <b>Hobart, Indiana</b>							
22a. EMBALMER'S NAME <b>Sherman G. Banks III</b>				22b. EMBALMER'S LICENSE NO. <b>FD01016254</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes									
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Sherman G. Banks III</i>				24b. LICENSE NUMBER (of Licensee) <b>FD01015177</b>		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Smith Bizzell Warner &amp; Son 4209 Grant St., Gary, Indiana 46408 FH88900011</b>									
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. <b>Cerebrovascular accident</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>arteriosclerotic cerebrovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF) c. <b>Generalized arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF) d. <b>arteriosclerosis</b> Approximate interval Between Onset and Death															
PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I. <b>Bronchopneumonia Dehydration</b>						27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>					
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) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alexander S. Williams, M.D.</i>						29c. MEDICAL LICENSE NO. <b>25043</b>		29d. DATE SIGNED (Month/Day/Year) <b>10/25/94</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. T. Krishnan Potti, M.D. 8308 Broadway Merrillville, Indiana 46410</b>															
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>										32. DATE FILED (Month, Day, Year) <b>November 26, 1994</b>					
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 <b>fall</b>							
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.											