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TICOR TITLE INSURANCE

2002 047360

INDIANA

2007 FEB 22 PM 3:57

RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MADELYN J. MACK, being first duly sworn upon oath, deposes and says:

1. That JOHN D. MACK died on OCTOBER 26, 1998, ~~at~~ at LAKE COUNTY, INDIANA.

2. That MADELYN J. MACK and JOHN D. MACK were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
Lots 1 to 5, both inclusive, in Block 6 in Manufacturers Addition to Hammond, as per plat thereof, recorded in Plat Book 2 page 23, in the Office of the Recorder of Lake County, Indiana.

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 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.

Madelyn J. Mack
MADELYN J. MACK

Subscribed and sworn to before me, a Notary Public, this 16th day of May, 10/ 2002

Thomas G. Schiller

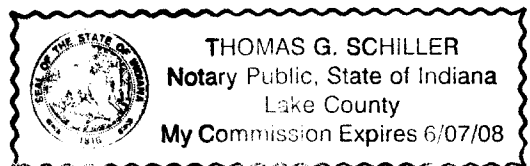
THOMAS G SCHILLER Notary Public

My Commission expires:

06-07-08

County of Residence:

Lake



This Instrument prepared by MADELYN J. MACK

12.00
M.V.
TI

92-21441

* 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. 2373-98

268239
TYPE/PRINT
IN
PERMANENT
BLACK INK

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

1. DECEASED—NAME (First, Middle, Last) John Darryl Mack				2. SEX Male		3a. TIME OF DEATH 8:30 P.M.		3b. DATE OF DEATH (Month, Day, Year) October 26, 1998				
4. *SOCIAL SECURITY NUMBER 306-34-6242			5a. AGE—Last Birthday (Years) 62		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) Jul. 17, 1936		7. BIRTHPLACE (City and State or Foreign Country) Sterling, Ill.	
8a. WAS DECEDENT A U.S. VETERAN? Yes		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						9c. CITY, TOWN, OR LOCATION OF DEATH Munster			9d. COUNTY OF DEATH Lake			
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Madelyn Palmer			12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Mechanical Supervisor			12b. KIND OF BUSINESS/INDUSTRY Steel Mills				
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Highland			13d. STREET AND NUMBER 8532 Cottage Grove Ave.,					
13e. ZIP CODE 46322		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 12 College (1-4 or 5+)		
18. FATHER'S NAME (First, Middle, Last) Vernon Mack						19. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Pagels						
20a. INFORMANT'S NAME (Type/Print) Madelyn Mack						20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8532 Cottage Grove Ave., Highland, Ind. 46322			20c. Relationship Wife			
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) October 29, 1998 Chapel Lawn				21c. LOCATION—City or Town, State Scherverville, Indiana				
22a. EMBALMER'S NAME Raymond E. White				22b. EMBALMER'S LICENSE NO. FD 08700086		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Slacanin</i>				24b. LICENSE NUMBER (of Licensee) FDO 1010850		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd., Highland, Ind.						
26. PART I. I HEREBY CERTIFY THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED WITH THE LAKE COUNTY HEALTH DEPT. I HAVE LISTED ALL CAUSES OF DEATH AND THE UNDERLYING CAUSE. Do not enter nonspecific terms, such as cardiac or respiratory. (Specify only highest grade completed.) IMMEDIATE CAUSE (Final disease or condition resulting in death) Non-Small Cell Lung Cancer III B 5 1/2 years OCT 27, 1998 Coronoidal Melanoma 20 months Coronary Artery Disease ALEXANDER S. WILLIAMS, M.D. 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)		
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. 01041301			29d. DATE SIGNED (Month, Day, Year) 10/27/98			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Chevy Morgan - #4416, M.D. 1636 45th ST. MUNSTER IN 46321												
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>						32. DATE FILED (Month, Day, Year) October 27, 1998						
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			
34a. 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.						

92.2144

