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LAKE COUNTY
FILED FOR RECORD

2002 063774

2002 JUL 16 AM 10:36

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

DOROTHY M. KINNARD, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, ROWIE E. KINNARD died (without leaving a will) ~~XXXXXXXXXXXXXXXX~~ on October 26, 19 99 at St. Anthony's Hospital, Crown Point, Indiana

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOTS 44 AND 45 IN BLOCK 1 IN F.D. BARNES' GARY ADDITION TO HOBART, AS PER PLAT THEREOF, RECORDED DECEMBER 20, 1912 IN PLAT BOOK 10 PAGE 27, IN THE OFFICE OF THE RECOREER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 3756 S. LIVERPOOL, HOBART, IN. 46342

UNIT 27 KEY NO. 17-46-43

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) ~~XXXX~~ death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. 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.

COMMUNITY TITLE COMPANY
FILE NO L 23567

Dorothy M. Kinnard
DOROTHY M. KINNARD

Subscribed and sworn to before me, a Notary Public, this 9th day of JULY, 2002, ~~19XX~~.

PATRICIA LUDINGTON
NOTARY PUBLIC, STATE OF INDIANA
COUNTY OF LAKE
MY COMMISSION EXPIRES 04-15-08

Patricia Ludington
Notary Public

THIS INSTRUMENT PREPARED BY: PATRICK McMANAMA, ATTORNEY AT LAW
ID 9534-45

FILED

JUL 11 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

000720

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

Local No. 2466-99

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

1. DECEASED–NAME (First Middle Last): ROWIE E. KINNARD
2. SEX: Male
3a. TIME OF DEATH: 6:30PM
3b. DATE OF DEATH (Month Day Yr): October 26, 1999
4. SOCIAL SECURITY NUMBER: 493-26-5406
5a. AGE - Last Birthday (Years): 71
5b. UNDER 1 YEAR (Months Days):
5c. UNDER 1 DAY (Hours Minutes):
6. DATE OF BIRTH (Mo Day Yr): February 24, 1928
7. BIRTHPLACE (City and State or Foreign Country): Elvins, Missouri
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: 1947
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY'S HOSPITAL
9c. CITY TOWN OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Dorothy M Wader
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Building Manager
12b. KIND OF BUSINESS INDUSTRY: Manager
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hobart
13d. STREET AND NUMBER: 3756 Liverpool Rd.
13e. ZIP CODE: 46342
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): 11; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Claude Kinnard
19. MOTHER'S NAME (First, Middle, Maiden Surname): Verna Neal

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Dorothy M Kinnard
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3756 Liverpool Rd., Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): October 29, 1999 CALVARY CREMATORY
21c. LOCATION - City or Town State: PORTAGE, Indiana
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Charles D. Scheuer Jr.
24b. LICENSE NUMBER (of Licensee): FDO1006049
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19300009 Rees Funeral Home, Brady Chapel 3781 Central Avenue , Lake Station, IN 46405

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)
a. Pulmonary emphysema — Approximate Interval Between Onset and Death: Yrs.
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions if any which gave rise to the immediate cause stating the underlying cause last

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.

29b. SIGNATURE AND TITLE OF CERTIFIER: R. Devanathan M.D.
29c. MEDICAL LICENSE NO: 01040141
29d. DATE SIGNED (Month Day Year): 10/28/99

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RAJA DEVANATHAN MD, 1600 S. LAKE PARK AVE, Suite 1104, HOBART, IN 46342
31. HEALTH OFFICER'S SIGNATURE: Alexander Stilianos MD
32. DATE FILED (Month Day Year): October 28, 1999

33. MANNER OF DEATH: [ ] 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, 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.:

OCT 28 1999