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STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

A F F I D A V I T

MARY M. YARDS, being first duly sworn, states:

1. She is a resident of Lake County, Indiana.

2. Affiant states that she is the surviving spouse of John J. Yards, who died a resident of Lake County, Indiana, on October 1, 1997. A certified copy of his death certificate is attached hereto and incorporated herein.

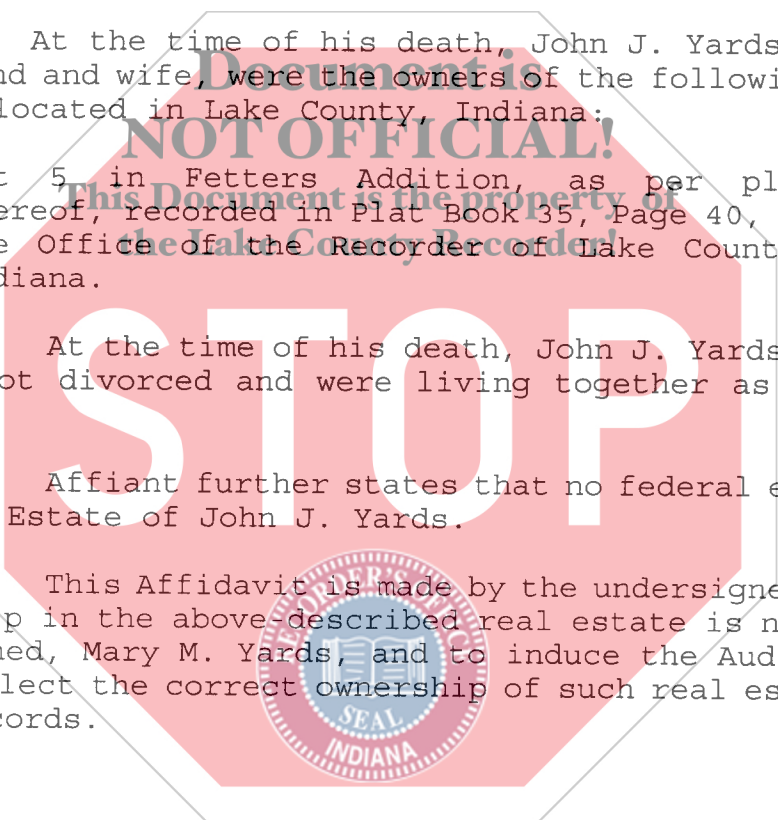
3. At the time of his death, John J. Yards and Mary M. Yards, husband and wife, were the owners of the following described real estate located in Lake County, Indiana:

Lot 5 in Fetters Addition, as per plat thereof, recorded in Plat Book 35, Page 40, in the Office of the Recorder of Lake County, Indiana.

4. At the time of his death, John J. Yards and Mary M. Yards were not divorced and were living together as husband and wife.

5. Affiant further states that no federal estate tax is due from the Estate of John J. Yards.

6. This Affidavit is made by the undersigned to confirm that ownership in the above-described real estate is now vested in the undersigned, Mary M. Yards, and to induce the Auditor of Lake County to reflect the correct ownership of such real estate on said Auditor's records.



DULY ENTERED FOR TAXATION SUBJECT TO  
FINAL ACCEPTANCE FOR TRANSFER

AUG 2 2002

PETER BENJAMIN  
LAKE COUNTY AUDITOR

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13.00  
M.V.  
1461

Dated June 25, 2002.

*Mary M Yards*  
\_\_\_\_\_  
MARY M. YARDS

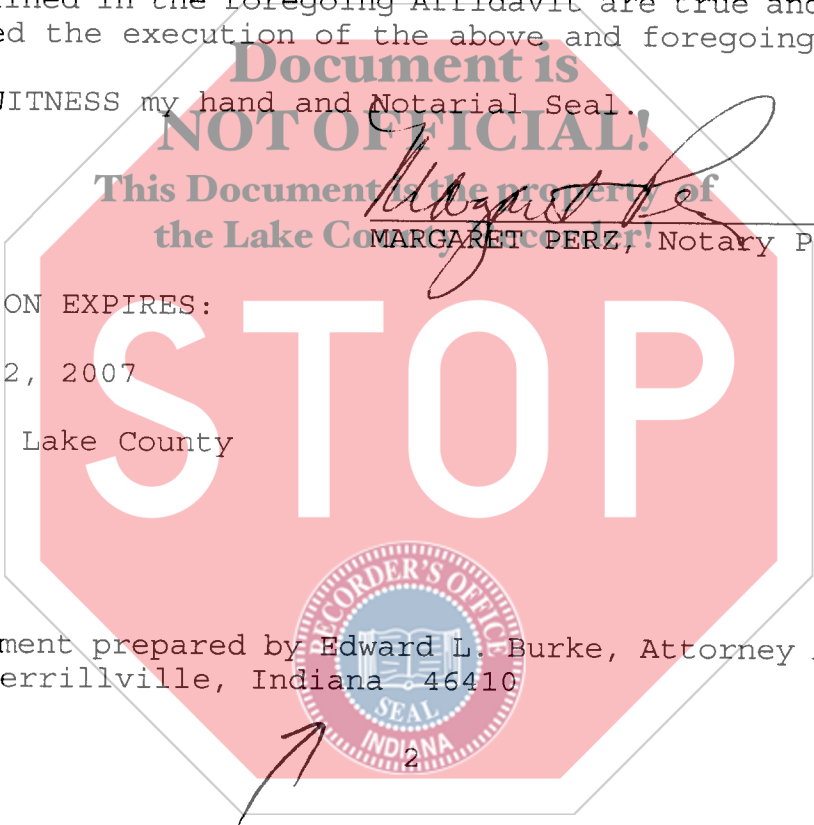
STATE OF INDIANA        )  
                                  ) SS:  
COUNTY OF LAKE        )

Before me, the undersigned, a Notary Public in and for said County and State, this 25<sup>th</sup> day of June, 2002, personally appeared Mary M. Yards, who, being duly sworn, stated that the facts contained in the foregoing Affidavit are true and correct and acknowledged the execution of the above and foregoing Affidavit.

WITNESS my hand and Notarial Seal.

**Document is NOT OFFICIAL!**  
*Margaret Perz*  
\_\_\_\_\_  
MARGARET PERZ, Notary Public

MY COMMISSION EXPIRES:  
September 12, 2007  
Resident of Lake County



This instrument prepared by Edward L. Burke, Attorney At Law, 9191 Broadway, Merrillville, Indiana 46410

\* 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. 2072-97

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>John J. Yards</b>			2. SEX <b>Male</b>		3a. TIME OF DEATH <b>07:20P</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>October 1, 1997</b>	
4. *SOCIAL SECURITY NUMBER <b>313-07-4425</b>		5a. AGE—Last Birthday (Year) <b>88</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>Aug 9, 1909</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>PA</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 type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				
9b. FACILITY NAME (If not institution, give street and number) <b>16005 Clark St.</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Lowell</b>		9d. COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Mary Majerle</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Shearman</b>			12b. KIND OF BUSINESS/INDUSTRY <b>Steel Factory</b>	
13a. RESIDENCE—STATE <b>IN</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Lowell</b>		13d. STREET AND NUMBER <b>16005 Clark St.</b>		
13e. ZIP CODE <b>46356</b>	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? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>	
18. FATHER'S NAME (First, Middle, Last) <b>John Jarc</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Angela Koncilya</b>				
20a. INFORMANT'S NAME (Type/Print) <b>Mary Yards</b>			20b. ADDRESS (Street, Number or Rural Route Number, City or Town, State, Zip Code) <b>16005 Clark St. Lowell, IN 46356</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 6, 1997 Calumet Park Cemetery</b>			21c. LOCATION—City or Town, State <b>Merrillville, IN</b>			
22a. EMBALMER'S NAME <b>Byron G. Hawkins</b>		22b. EMBALMER'S LICENSE NO. <b>FD29500038</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Molly E. Herlihy</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO9200061</b>		25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Sheets Funeral Home, PH83004277 604 E. Commercial Ave. Lowell, IN</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. <b>Pancreatic Cancer</b>								
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. DUE TO (OR AS A CONSEQUENCE OF)		b. DUE TO (OR AS A CONSEQUENCE OF)		c. DUE TO (OR AS A CONSEQUENCE OF)		
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		d. DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death				
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) <b>NO</b>		28a. WERE AUTOPSY FINDINGS PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</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>R. S. Draga</i>				29c. MEDICAL LICENSE NO. <b>01031484</b>		29d. DATE SIGNED (Month, Day, Year) <b>10/6/97</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Ray E. Draga MD, 8127 Merrillville Rd., Merrillville, IN 46410</b>								
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>						32. DATE FILED (Month, Day, Year) <b>October 8, 1997</b>		
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			
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) <b>10/01/97</b>		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.						