(1)

3

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2002 101693

2002 NOV -7 AM 10: 13

MORRIS W. CARTER
RECORDER

Chicago Title Insurance Company

## SURVIVORSHIP AFFIDAVIT

2002480BT

On this 10/31/02 (insert date) before me personally appeared

CRAIG BUFORD

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is OWNER; (state interest of affiant in the above premises as "owner", "son of owner", etc.)
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by CRAIG BUFORD and BONNIE J. BUFORD;
4. Said BONNIE J. BUFORD (fill in name of co-tenant who died)

   died on 05/16/02

   leaving ____ will; (insert "a" or "no"; if will left, attach a copy)
5. The legal description of the premises in question is:

   LOT 5 IN BLOCK 3 IN CRESTWOOD PARK SECOND SUBDIVISION, IN THE CITY OF HOBART, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 32, PAGE 71 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☑ No

   If yes, then estimated taxes due are $ ____

   The taxes due are ☐ paid or ☐ unpaid.

FILED
NOV 6 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

000432

CK
14.00

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

NO

(If answer is "Yes," identify the divorce proceedings:

);

8. Affiant's relationship to the deceased was SPOUSE

Signature: Craig R Buford

Printed Name CRAIG BUFORD

Address:



Subscribed and sworn to before me by the affiant

this 31ST DAY OF OCTOBER, 2002
(insert date)

Kelly M Reed
Notary Public

Printed Name KELLY M. REED

My County of Residence is: PORTER

In the State of INDIANA

My Commission Expires 11/15/09

This instrument prepared by CRAIG BUFORD

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

Local No. 1081-01

384539

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No.....

TYPE/PRINT IN PERMANENT BLACK INK

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

**DECEDENT**

| 1. DECEASED - NAME (First, Middle, Last) | | | 2. SEX | 3a. TIME OF DEATH | 3b. DATE OF DEATH (Month, Day, Yr.) |
|---|---|---|---|---|---|
| Bonnie | J. | Buford | Female | 2:00 AM | May 16, 2001 |

| 4. *SOCIAL SECURITY NUMBER | 5a. AGE - Last Birthday (Years) | 5b. UNDER 1 YEAR (Months / Days) | 5c. UNDER 1 DAY (Hours / Minutes) | 6. DATE OF BIRTH (Mo., Day, Yr.) | 7. BIRTHPLACE (City and State or Foreign Country) |
|---|---|---|---|---|---|
| 307-52-3854 | 52 | | | March 03, 1949 | Hammond Indiana |

| 8a. WAS DECEDENT A U.S. VETERAN? | 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? |
|---|---|
| No | --- |

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) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH |
|---|---|---|
| St. Mary Medical Center | Hobart | Lake |

| 10. MARITAL STATUS (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) | 12b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Married | Craig Buford | Travel Agent | World Travel |

| 13a. RESIDENCE - STATE | 13b. COUNTY | 13c. CITY, TOWN OR LOCATION | 13d. STREET AND NUMBER |
|---|---|---|---|
| Indiana | Lake | Hobart | 258 Softwood Drive |

| 13e. ZIP CODE | 13f. INSIDE CITY LIMITS | 13g. ON A FARM? | 14. CITIZEN OF WHAT COUNTRY? | 15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 16. RACE - American Indian, Black, White, etc. (Specify) | 17. DECEDENT'S EDUCATION (Specify only highest grade completed) | |
|---|---|---|---|---|---|---|---|
| | | | | | | Elementary/Secondary (0-12) | College (1-4 or 5+) |
| 46342 | [ ] No [X] Yes | [X] No [ ] Yes | USA | [X] No [ ] Yes | White | 12 | N/A |

**PARENTS**

| 18. FATHER'S NAME (First, Middle, Last) | 19. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William Busch | Betty Jones |

**INFORMANT**

| 20a. INFORMANT'S NAME (Type/Print) | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 20c. Relationship |
|---|---|---|
| Craig R. Buford | 258 Softwood Drive, Hobart, IN 46342 | Husband |

**DISPOSITION**

| 21a. METHOD OF DISPOSITION | 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 21c. LOCATION - City or Town, State |
|---|---|---|
| [X] Burial [ ] Cremation [ ] Removal from state [ ] Donation [ ] Other (Specify) [ ] Entombment | May 19, 2001 Chapel Lawn Memorial Gardens | Schererville, Indiana |

| 22a. EMBALMER'S NAME | 22b. EMBALMER'S LICENSE NO | 23. WAS DEATH REPORTED TO CORONER? |
|---|---|---|
| Terrence P. Burns | 01013890 | [X] No [ ] Yes |

| 24a. SIGNATURE OF FUNERAL DIRECTOR | 24b. LICENSE NUMBER (of Licensee) | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME |
|---|---|---|
| James F. Burns | FD01009461 | Burns Funeral Home FH83002380 701 E. 4th Street, Hobart, Indiana 46342 |

**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. Cancer Breast

DUE TO (OR AS A CONSEQUENCE OF):

b. Lung Mets

DUE TO (OR AS A CONSEQUENCE OF):

c. Brain Mets

DUE TO (OR AS A CONSEQUENCE OF):

d.

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

(THIS CERTIFIES THAT ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.)

MAY 16 2002

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? (Y, N, or U) | 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) | 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) |
|---|---|---|
| N | 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) 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) stated.

| 29c. SIGNATURE AND TITLE OF CERTIFIER | 29d. MEDICAL LICENSE NO | 29e. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mark Carter | 01036415 | 5/16/01 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)

Mark Carter M.D. 295 S. Wisconsin Street, Hobart, IN 46342

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE

32. DATE FILED (Month, Day, Year) May 16, 2001

| 33. MANNER OF DEATH | 34a. DATE OF INJURY (Month, Day, Year) | 34b. TIME OF INJURY | 34c. INJURY AT WORK? (Yes or no) | 34d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined | | | | |

| 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. |
|---|---|
| May 16, 2001 | |

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