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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2002 106625

TICOR TITLE INSURANCE

2002 NOV 21 AM 8:57

MORRIS W. CARTER
RECORDER

SURVIVORSHIP AFFIDAVIT

STATE OF: INDIANA)

) SS:

COUNTY OF: PORTER)

On this 11-5-02 Before me personally appeared Yousef H. Mohammad

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)

- 3. Said premises described as follows: Lot 78 in Unit 1 in Casa Bella 2nd Addition,
to the Town of Schererville, as per plat thereof, recorded in Plat Book 51,
page 78, in the Office of the Recorder of Lake County, Indiana.

NOT OFFICIAL

13-326-38 (20)

**This Document is the property of
the Lake County Recorder!**

- 4. Said premises were formerly owned as joint tenants or as tenants by entireties
by Yousef H. Mohammad and Theresa J. Mohammad

- 5. Said Theresa J. Mohammad
(fill in name of co-tenant who died)

died on _____
leaving _____ will;
(insert "a" or "no" if a will has been left, attach a copy)

- 6. The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of \$ _____ and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of the said decedent:

- 7. Where this affidavit relates to a tenancy of the entireties, were the parties ever divorced? NO
(If answer is YES, identify the dissolution proceedings.)

- 8. Affiant's relationship to the deceased was husband

Signature Yousef H. Mohammad

Address: Yousef H. Mohammad

State of Indiana)

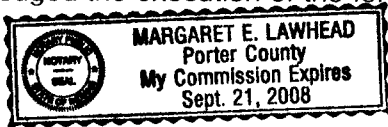
County of Porter)

Before me, the undersigned, a Notary Public in and for said County and State, this NOV 20 2002
personally appeared Yousef H. Mohammad

DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER

PETER BENJAMIN
LAKE COUNTY AUDITOR

and acknowledged the execution of the foregoing Affidavit



Margaret E. Lawhead
Margaret E. Lawhead Notary Public
Resident of Porter County
My Commission expires: 9-21-08

Prepared by: Yousef H. Mohammad

001510

9200 25595

Handwritten initials/signature

CERTIFICATE OF DEATH

State No.

Local No. 1350-01

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

RE/PRINT IN PERMANENT INK

SECTION

MENTS

FORM

OSITION

E OF

IES

?

1 DECEASED—NAME (First Middle Last) THERESA J. MERSION MOHAMMAD		2 SEX FEMALE	3a TIME OF DEATH 5:50 A. M.	3b DATE OF DEATH (Month Day Year) JUNE 15, 2001	
4 *SOCIAL SECURITY NUMBER 356-40-7187		5a AGE—Last Birthday (Years) 50	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	
6a WAS DECEDENT A U.S. VETERAN? NO		6b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		6 DATE OF BIRTH (Mo Day Yr) OCTOBER 6, 1950	
7 BIRTHPLACE (City and State or Foreign Country) ENGLAND		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER: Outpatient <input type="checkbox"/> DQA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution give street and number) ST. MARGARET MERCY SOUTH		9c CITY, TOWN OR LOCATION OF DEATH DYER		9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED		11 SURVIVING SPOUSE (If wife give maiden name) YOUSSEF MOHAMMAD		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) NURSE	
12b KIND OF BUSINESS/INDUSTRY HOSPITAL		13a RESIDENCE—STATE INDIANA			
13b COUNTY LAKE		13c CITY, TOWN OR LOCATION SCHERERVILLE		13d STREET AND NUMBER 2622 CAPRI DRIVE	
13e ZIP CODE 46375		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? 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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		18 FATHER'S NAME (First Middle Last) BRONISLAW KOLASA			
19 MOTHER'S NAME (First Middle Maiden Surname) ZOFIA GURGUL			20a INFORMANT'S NAME (Type/Print) YOUSSEF MOHAMMAD		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2622 CAPRI DR. SCHERERVILLE, IN. 46375			20c Relationship HUSBAND		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <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) JUNE 19, 2001 HOLY CROSS CEMETERY		21c LOCATION—City or Town, State CALUMET CITY IL. 60409	
22a EMBALMER'S NAME SCOTT J. PREWITT		22b EMBALMER'S LICENSE NO. FDO 1006861		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Scott J. Prewitt</i>		24b LICENSE NUMBER (of Licensee) FDO 1006015		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FAGEN-MILLER FUNERAL HOME F183001504 1920 HART ST. DYER IN 46311	
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.					Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) Cardio Pulmonary DUE TO (OR AS A CONSEQUENCE OF)					Minutes
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last Cardio Pulmonary DUE TO (OR AS A CONSEQUENCE OF)					2 years
PART II Other significant conditions: Conditions contributing to death but not previously stated in Part I Obtuse, marked obesity Type II DM, Sleep apnea					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? NO		28a WAS AN AUTOPSY PERFORMED? NO		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A	
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>Susan J. Best</i>				29c MEDICAL LICENSE NO. 01057342	
29d DATE SIGNED (Month Day Year) 6/18/01					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 6b) (Year, Print) DR. KATHRYN MULLIGAN 8919 MAW ST. DYER IN 46311					
31 HEALTH OFFICER'S SIGNATURE <i>Susan J. Best</i>					
32 DATE FILED (Month Day Year) June 18, 2001					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.			

