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TICOR TITLE INSURANCE

2003 1003782

AFFIDAVIT

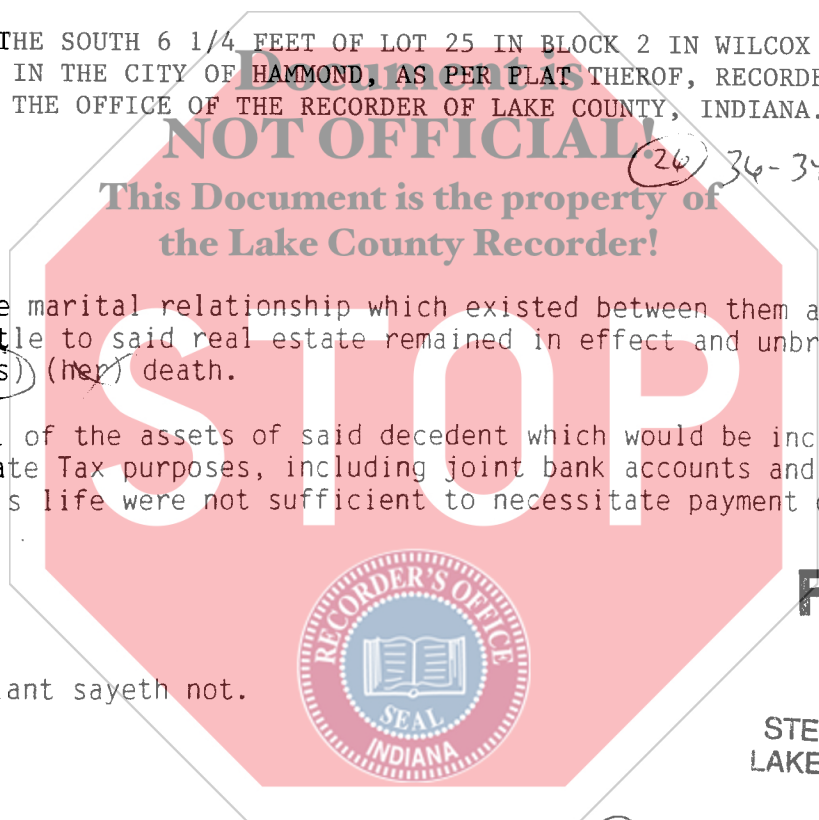
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

DOROTHY J. DAVIS, being first duly sworn upon oath, deposes and says:

1. That CARL KENNETH DAVIS died on 12-25, 1992 at ST. MARGARETS MERCY HOSPITAL.

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

LOT 24 AND THE SOUTH 6 1/4 FEET OF LOT 25 IN BLOCK 2 IN WILCOX FIRST ADDITION TO WHITING, IN THE CITY OF HAMMOND, AS PER PLAT THEROF, RECORDED IN PLAT BOOK 2 PAGE 51, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.



(26) 36-346-24

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.

FILED

OCT 2 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Dorothy J. Davis
DOROTHY J. DAVIS

Subscribed and sworn to before me, a Notary Public, this 25TH day of SEPT, 19 2003.

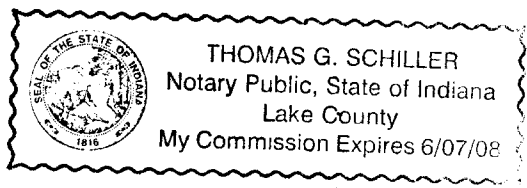
[Signature] **000201**
THOMAS G. SCHILLER Notary Public

My Commission expires:

6/7/08

County of Residence:

LAKE



This Instrument prepared by DOROTHY J. DAVIS

TICOR TITLE INSURANCE 920036771
2050-45TH AVE
HIGHLAND, IN 46322

1200
DKM
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* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jan 2, 2003
Date Issued
Hammond Health Commissioner

Local No. 1024

State IN

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) CARL KENNETH DAVIS		2. SEX MALE		3a. TIME OF DEATH 3:18 A.M.		3b. DATE OF DEATH (Month, Day, Year) DEC 25 2002	
4. *SOCIAL SECURITY NUMBER 352-52-8478		5a. AGE—Last Birthday (Years) 66		5b. UNDER 1 YEAR Months: Days:		5c. UNDER 1 DAY Hours: Minutes:	
5d. DATE OF BIRTH (Mo, Day, Yr) JAN 1-1-36		7. BIRTHPLACE (City and State or Foreign Country) ELLIWAY GEORGIA					
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1973		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) St. MARGARETS MERCY Hospital				9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) DOROTHY BLASTIC		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) N/A		12b. KIND OF BUSINESS/INDUSTRY N/A	
13a. RESIDENCE—STATE IN		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION Whiting		13d. STREET AND NUMBER 2749 New York Ave	
13e. ZIP CODE 46394		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) White		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2			
18. FATHER'S NAME (First, Middle, Last) Overton DAVIS				19. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Maxnor			
20a. INFORMANT'S NAME (Type/Print) DOROTHY DAVIS				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2749 New York Ave Whiting IN		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) December 12-30-02 Holy Cross			21c. LOCATION—City or Town, State Calumet City Ill	
22a. EMBALMER'S NAME Thomas Owens			22b. EMBALMER'S LICENSE NO. 10001049		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas Owens</i>			24b. LICENSE NUMBER (of Licensee) 10001049		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Owens FH 816-119th St Whiting 3007291		
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)							
a. ACUTE MYOCARDIAL INFARCTION MINUTES							
b. OLD MYOCARDIAL INFARCTION YEARS							
c. CHRONIC OBSTRUCTIVE LUNG DISEASE YEARS							
d. HYPERTENSIVE HEART DISEASE YEARS							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
Hyperlipidemia							
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			
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 checked="" 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>Franklin J. Spemuda M.D.</i>						29c. MEDICAL LICENSE NO. 02001161	
29d. DATE SIGNED (Month, Day, Year) 12/30/02							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. CH Foreit DO, 153 Basline Ave Griffith IN 46319							
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Spemuda M.D.</i>						32. DATE FILED (Month, Day, Year) January 2, 2003	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

923-6771
(26) 36-346-24

TIGOR HO

