2

TICOR TITLE INSURANCE

2003 105482

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, 19 2002 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.

000201

THOMAS G. SCHILLER Notary Public

My Commission expires:

6/7/08

County of Residence:

LAKE

THOMAS G. SCHILLER
Notary Public, State of Indiana
Lake County
My Commission Expires 6/07/08

This Instrument prepared by DOROTHY J. DAVIS

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

92003671

D20 KM
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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.

Local No. 1024

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

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): CARL KENNETH DAVIS
2. SEX: MALE
3a. TIME OF DEATH: 3:18 AM
3b. DATE OF DEATH (Month, Day, Yr): December 12-25-02
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
6. DATE OF BIRTH (Mo, Day, Yr): JAN 1-1-36
7. BIRTHPLACE (City and State or Foreign Country): ELLIJAY 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 ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ 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 ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12; College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): OVERTON DAVIS
19. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE MAYNOR

INFORMANT

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

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____ ☐ Entombment
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 IN
22a. EMBALMER'S NAME: THOMAS OWENS
22b. EMBALMER'S LICENSE NO: 1001049
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Don Owens
24b. LICENSE NUMBER (of Licensee): 1001049
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3007291 OWENS FH 816-119TH ST WHITING

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. ACUTE MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: MINUTES

DUE TO (OR AS A CONSEQUENCE OF)
b. OLD MYOCARDIAL INFARCTION — YEARS

DUE TO (OR AS A CONSEQUENCE OF)
c. CHRONIC OBSTRUCTIVE LUNG DISEASE — YEARS

DUE TO (OR AS A CONSEQUENCE OF)
d. HYPERTENSIVE HEART DISEASE — YEARS

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: 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

923-6771
(2) 36-346-24

CERTIFIER

29a. CERTIFIER (Check only one)
☒ 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: [signature], DO
29c. MEDICAL LICENSE NO: 02001161
29d. DATE SIGNED (Month, Day, Year): 12/30/02 (December)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. CA Foreit DO 1513 Pipeline Ave Griffith IN 46319

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Bermuda M.D.
32. DATE FILED (Month, Day, Year): January 2, 2003

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.

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