(1)

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Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

On this 9/19/03 before me personally appeared
(insert date)

FRANCIS ANDERSON

2003 105871

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

1. Affiant resides at the address given below affiant's signature:
   221 ISLAND DRIVE
   LOWELL, INDIANA 46356
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 EMMETT ANDERSON and FRANCIS ANDERSON;

4. Said EMMETT ANDERSON
   (fill in name of co-tenant who died)
   died on MAY 22, 1996
   leaving NO will;
   (insert "a" or "no"; if will left, attach a copy

5. The legal description of the premises in question is:

PARCEL I: Lots 1, 2 and 3 in Block 27 in Dalecarlia, as per plat thereof, recorded in Plat Book 23 page 61, in the Office of the Recorder of Lake County, Indiana.

PARCEL II: Lots 33, 34 and a part of Lot 32 in Block 28 in Dalecarlia, as per plat thereof, recorded in Plat Book 26 page 30, in the Office of the Recorder of Lake County, Indiana, said part of Lot 32 in Block 28 being more particularly described as follows, to-wit: Beginning at the Northwest corner of Lot 1 in Block 27 in Dalecarlia, thence Northwesterly along the Southwesterly line of said Lot 32 a distance of 18 feet; thence Northeasterly to a point on the Northerly line of said Lot 32, said point being 10 feet Southwesterly of the Northeasterly corner of said Lot 32; thence Northeasterly 10 feet to the Northeasterly corner of said Lot 32; thence Southwesterly along the Southeasterly line of said Lot 32 to the Southeasterly corner thereof; thence West to the place of beginning.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
SEP 2 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

6. Is there Federal 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..

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SOUTHSHORE TITLE LLC
11055 BROADWAY
CROWN POINT, IN 46307

SOUTHSHORE TITLE LLC
99003134

14.00 KM 53

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: Francis Anderson

Printed Name FRANCIS ANDERSON

Address: 221 ISLAND DRIVE

LOWELL, INDIANA 46356

Subscribed and sworn to before me by the affiant

This 9/19/03
(insert date)

Debra Lewis
Notary Public

Printed Name _____

My County of Residence is: _____

In the State of _____

My Commission Expires _____

"OFFICIAL SEAL"
Debra Lewis
Notary Public, State of Indiana
My Commission Expires 9-9-2006

This instrument prepared by AUSTIN P LOGUE, MD

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

OCT 2 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

* **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. 10230-96

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Emmett James Anderson	Male	6:00 p M	May 22, 1996

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)
310-22-2855	69			April 23, 1927	Danville, Illinois

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
Yes		HOSPITAL: ☒ 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
Munster Community Hospital	Munster	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	Frances Vanslyke	Retired Fireman	Hammond Fire Dept.

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Lowell	221 Island 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 +)
46356	☒ No ☐ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12	0

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John Anderson	Mabel Stump

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
Frances Anderson	221 Island Drive, Lowell, Indiana 46356	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 25, 1996 Chapel Lawn Memorial Gardens	Schererville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
William E. Burdan	FD01007697	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
William E. Burdan	FD01007697	BURDAN FUNERAL HOME FH83002461 12901 Wicker Ave., CedarLK, IN 46303

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Severe Coronary Artery Occlusion Disease	4 years
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF) b.	Congestive Cardiomyopathy	4 years
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

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	29c. MEDICAL LICENSE NUMBER	DATE ACCEPTED FOR TAXATION (Month, Day, Year)
A. Gandhi	01029887	5/24/96

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Dr. Arvind Gandhi, 9122 Columbia Ave., Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander Williams, M.D.

32. DATE FILED (Month, Day, Year): OCT 2 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

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 ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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