

3



# 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:

- Affiant resides at the address given below affiant's signature:  
221 ISLAND DRIVE  
LOWELL, INDIANA 46356
- Affiant is \_\_\_\_\_ OWNER  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

- Said premises were formerly owned as joint tenants or as tenants by the entireties by EMMETT ANDERSON and FRANCIS ANDERSON;

- 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)

- 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 23 page 30, in the Office of the Recorder of Lake County, Indiana, said part of Lot 32 in Block 28 in Dalecarlia, 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.

- Is there Federal or State inheritance tax liability by reason of the death of the decedent?  Yes  No

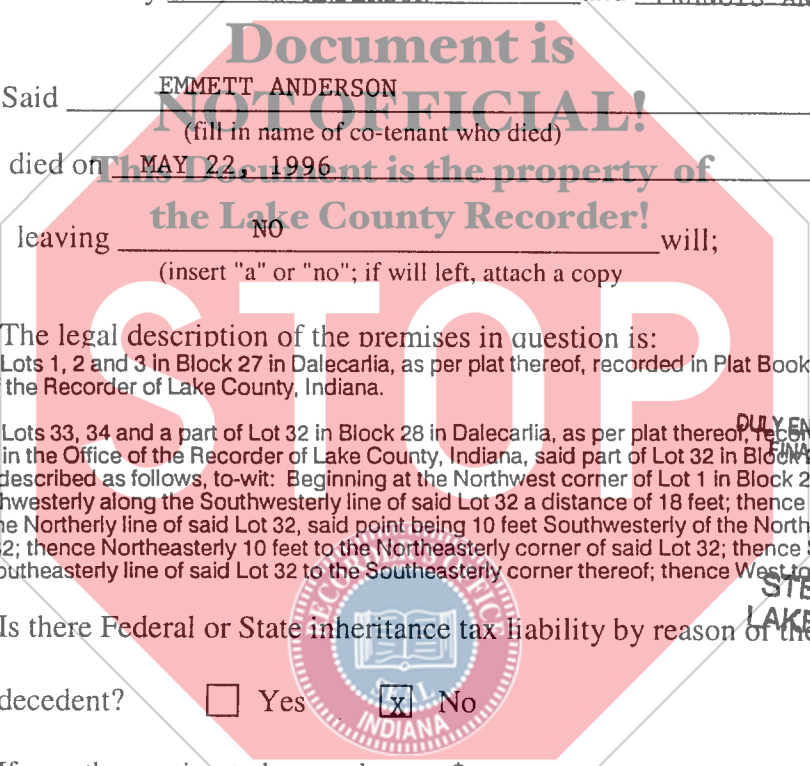
If yes, then estimated taxes due are \$ \_\_\_\_\_

The taxes due are  paid or  unpaid..

000160

SOUTHSHORE TITLE LLC  
11055 BROADWAY  
CROWN POINT, IN 46307

SOUTHSHORE TITLE LLC  
990031341



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)

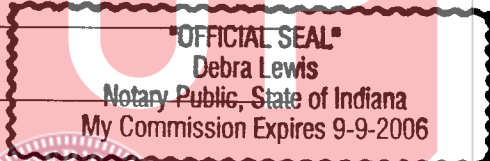
Debra Lewis  
Notary Public

Printed Name \_\_\_\_\_

My County of Residence is: \_\_\_\_\_

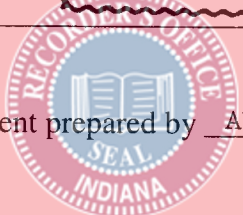
In the State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_



DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

This instrument prepared by AUSTIN P LOGUE, MD ACT 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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0020-96

State No. \_\_\_\_\_

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>Emmett James Anderson</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>6:00 p M</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>May 22, 1996</b>
4. *SOCIAL SECURITY NUMBER <b>310-22-2855</b>	5a. AGE—Last Birthday (Years) <b>69</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>April 23, 1927</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Danville, Illinois</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	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) <b>Munster Community Hospital</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Munster</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Frances Vanslyke</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Retired Fireman</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Hammond Fire Dept.</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Lowell</b>	13d. STREET AND NUMBER <b>221 Island Drive</b>	
13e. ZIP CODE <b>46356</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		18. FATHER'S NAME (First, Middle, Last) <b>John Anderson</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel Stump</b>		20a. INFORMANT'S NAME (Type/Print) <b>Frances Anderson</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>221 Island Drive, Lowell, Indiana 46356</b>		20c. Relationship <b>Wife</b>		
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) <b>May 25, 1996 Chapel Lawn Memorial Gardens</b>		21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>
22a. EMBALMER'S NAME <i>William E. Dyer</i>		22b. EMBALMER'S LICENSE NO. <b>FD01007697</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>William E. Dyer</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01007697</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BURDAN FUNERAL HOME FH83002461 12901 Wicker Ave., CedarLK, IN 46303</b>	
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				
THIS CERTIFICATE IS VALID FOR USE (Final discharge of the decedent resulting from death)				
a. <b>Seven coronary artery occlusion Disease</b> <b>4 years</b>				
b. <b>longerhin andromyopathy</b> <b>4 years</b>				
c. _____				
d. _____				
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)				
29a. CERTIFIER (Check only one) <input 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) as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Gandhi</i>		29c. MEDICAL ACCEPTANCE FOR TRANSFER (Month, Day, Year) <b>01029887 5124196</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>Dr. Arvind Gandhi, 9122 Columbia Ave., Munster, Indiana 46321</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Stephen R. Stiglich, M.D.</i>				32. DATE FILED (Month, Day, Year) <b>NOV 2 2003</b>
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.		

000161