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TICOR TITLE INSURANCE

2003 107800

STATE OF INDIANA
LAKE COUNTY
2003 OCT -3 10:34
NOV 22 12:44-22

AFFIDAVIT

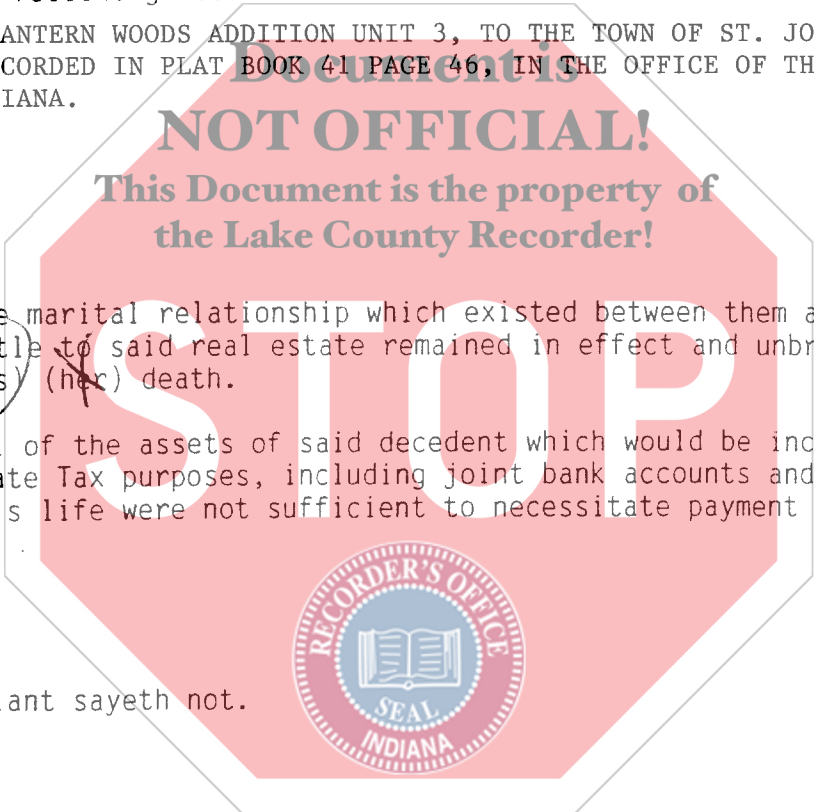
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JOAN B. SMITH, being first duly sworn upon oath, deposes and says:

1. That HENRY A. SMITH died on August 05, 2002, ~~1944~~ at Lake County, Indiana.

2. That HENRY A. SMITH and JOAN B. SMITH were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 69 IN LANTERN WOODS ADDITION UNIT 3, TO THE TOWN OF ST. JOHN, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 41 PAGE 46, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.



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.

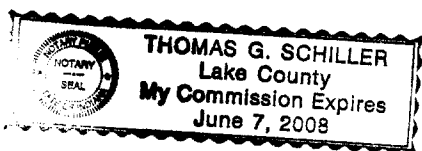
4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Joan B. Smith
JOAN B. SMITH

Subscribed and sworn to before me, a Notary Public, this 2ND day of OCT., 11th 2003.

REC'D FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER



Stephen R. Stiglich
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR
THOMAS G. SCHILLER Notary Public

My Commission expires:

6/7/08

County of Residence:

LAKE

000584

This Instrument prepared by JOAN B. SMITH

TICOR HO

12-DC
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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

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

Local No. 017

CERTIFICATE OF DEATH

RAISED SEAL

Aug 7 2002 Date Issued

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) Henry Alfred Smith				2. SEX Male		3a. TIME OF DEATH 1:39 A M		3b. DATE OF DEATH (Month, Day, Yr.) August 5, 2002	
4. *SOCIAL SECURITY NUMBER 316-24-5840		5a. AGE—Last Birthday (Years) 73		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) September 10, 1928	
7. BIRTHPLACE (City and State or Foreign Country) Madison, IL		8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1952		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. Margaret Mercy, North Campus				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) Joan B. Kygiel		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Car Inspector			12b. KIND OF BUSINESS/INDUSTRY IHB Railroad		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Crown Point			13d. STREET AND NUMBER 7430 W. 90th Lane		
13e. ZIP CODE 46307		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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) 12 College (1-4 or 5+) 12			18. FATHER'S NAME (First, Middle, Last) Henry Smith		19. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Clifton		
20a. INFORMANT'S NAME (Type/Print) Joan B. Smith				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7430 W. 90th Lane, Crown Point, IN46307				20c. Relationship Wife	
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) August 9, 2002 Chapel Lawn Memorial Gardens				21c. LOCATION—City or Town, State Scherverville, IN	
22a. EMBALMER'S NAME Henry J. Blake				22b. EMBALMER'S LICENSE NO. FD01019406		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Walter B. Ferguson</i>				24b. LICENSE NUMBER (of Licensee) FD01000857		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc., FH19400005 6955 Southeastern Ave., Hammond, IN4632			
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. <u>Aortic Dissection</u> DUE TO (OR AS A CONSEQUENCE OF) b. _____ 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 <u>Renal failure</u> <u>Cardiomyopathy</u>									
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 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>Kenneth J. Ramsey, DO</i>						29c. MEDICAL LICENSE NO. 02006963		29d. DATE SIGNED (Month, Day, Year) August 6, 2002	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Kenneth J. Ramsey, DO, 24 Joliet St., Dyer, IN 46311									
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Stremuda, M.D.</i>							32. DATE FILED (Month, Day, Year) August 7, 2002		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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		
34a. 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.					