2

TICOR TITLE INSURANCE

2003 107848

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JAMES ALLEN O'DONNELL
sworn upon oath, deposes and says:

1. That Affiant's spouse, HELEN G O'DONNELL died (without leaving a will) (leaving a will on) JANUARY 7, XX2003 at HAMMOND, INDIANA

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

LOT 16 IN FORSYTH HIGHLANDS 4TH ADDITION, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 28, PAGE 53, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 2003 OCT 15 AM 9:39 MORRIS W. CARTER RECORDER

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 XXXX death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

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

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STOP

Further affiant sayeth not.

James Allen O'Donnell
JAMES ALLEN O'DONNELL

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
OCT 7 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Subscribed and sworn to before me, a Notary Public, this 27TH day of SEPTEMBER, 2003

Karen M. Laude
KAREN M. LAUDE, Notary

My Commission expires:
02/21/2009

County of Residence:
LAKE

This Instrument prepared by JAMES ALLEN O'DONNELL

SOUTHSHORE TITLE LLC
11055 BROADWAY
CROWN POINT, IN 46307

SOUTHSHORE TITLE LLC
9403/43

000569

12.00
88

* 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. ....11..........................

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.

Sept 29, 2003 — Date Issued — [signature] 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): Helen Grace O'Donnell
2. SEX: Female
3a. TIME OF DEATH: 2"15A M
3b. DATE OF DEATH (Month, Day, Yr): January 7, 2003
4. *SOCIAL SECURITY NUMBER: 316-24-8526
5a. AGE—Last Birthday (Years): 88
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): March 3, 1914
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St Margaret Mercy Hospital-North
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): Jim O'Donnell
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housekeeping Supervisor
12b. KIND OF BUSINESS/INDUSTRY: Medical
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 6804 Waveland
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Charles DeZamko
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Harverlla

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Jim O'Donnell
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6804 Waveland Hammond, Indiana 46324
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 9, 2003 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Edward F. Mullaney
22b. EMBALMER'S LICENSE NO.: FDO 1007176
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO 1006015
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Fagen-Miller Funeral Homes Inc 2828 Highway Ave Highland, IN. 46322 FH83003035

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. Pleural effusion
DUE TO (OR AS A CONSEQUENCE OF):
b. Pneumothorax.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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.

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

CERTIFIER

29a. CERTIFIER (Check only one)
[X] 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: Jayesh Madhani [signature]
29c. MEDICAL LICENSE NO.: 01044088
29d. DATE SIGNED (Month, Day, Year): 1/8/03 (January)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Jayesh Madhani 2075 Indianapolis Blvd Whiting IN 46394

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin [signature] M.D.
32. DATE FILED (Month, Day, Year): January 10, 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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