3

TICOR TITLE INSURANCE

AFFIDAVIT

2003 112507

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

James A. Byrnes, being first duly sworn upon oath, deposes and says:

1. ~~That Affiant's spouse,~~ Melvina G. Byrnes died ~~(without leaving a will)~~ (leaving a will) on March 25, 1995 at Crown Point, 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:

See Attached

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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 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 joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

FILED
OCT 17 2003
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Further affiant sayeth not.

James A. Byrnes

Subscribed and sworn to before me, a Notary Public, this 14th day of October, ~~19~~ 2003.

Philip J. Ignarski Notary Public

My Commission expires: 07/17/06

PHILIP J. IGNARSKI
Notary Public, State of Indiana
Lake County
My Commission Expires 07/17/06

County of Residence:

This Instrument prepared by James A. Byrnes

001417

TICOR TITLE INSURANCE
11055 BROADWAY SUITE A
CROWN POINT, INDIANA 46307
920037910

14.
DG
TI

No: 920037910

LEGAL DESCRIPTION

Apartment A-85 in Building 8, Phase V in Four Seasons Lakeside Condominiums Horizontal Property Regime, as recorded July 8, 1976 as Document No. 358499, as amended and supplemented by First, Second, Third and Fourth Amendments recorded respectively on April 7, 1977 as Document No. 400888, on October 26, 1977 as Document No. 435747, on April 7, 1978 as Document No. 461816 and on September 22, 1978 as Document No. 491993 in the Office of the Recorder of Lake County, Indiana., together with an undivided interest in the common areas and facilities appertaining thereto.

10cc

ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0712-95 State No.

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TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MELVINA G BYRNES
2. SEX: FEMALE
3a. TIME OF DEATH: 5:50 P M
3b. DATE OF DEATH (Month, Day, Yr): MARCH 25, 1995
4. *SOCIAL SECURITY NUMBER: 340-01-072X
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): MARCH 30, 1916
7. BIRTHPLACE (City and State or Foreign Country): DYER, 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. ANTHONY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): WIDOW
11. SURVIVING SPOUSE (If wife, give maiden name): NONE
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): RET.ADMINISTRATIVE ASS'T
12b. KIND OF BUSINESS/INDUSTRY: INTERNATIONAL ASS'N FAIRS & EXPOS
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 2551 N. LAKE SHORE DRIVE
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: [X] No [ ] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): LOUIS M HARTMANN
19. MOTHER'S NAME (First, Middle, Maiden Surname): MATILDA HOFFMAN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CAROL ALLEN
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5508 West 133rd, CROWN POINT, IN 46307
20c. Relationship: DAUGHTER

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): MARCH 29, 1995 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE INDIANA
22a. EMBALMER'S NAME: RUSSELL KRAFT
22b. EMBALMER'S LICENSE NO.: 29300105
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Terrence P. Burns
24b. LICENSE NUMBER (of Licensee): 1013890
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445

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 cerebral infarction (stroke) — Approximate Interval Between Onset and Death: 24 hrs.

DUE TO (OR AS A CONSEQUENCE OF): b.

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): N/A

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: L M Salberg MD
29c. MEDICAL LICENSE NO.: 01025163
29d. DATE SIGNED (Month, Day, Year): 3/28/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Larry M Salberg, 521 E. 86th, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D.
32. DATE FILED (Month, Day, Year): March 28, 1995

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.

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

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