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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 037042

2004 MAY 5 AM 11:01

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT

Comes now William E. Spork, being duly sworn upon his oath and states as follows:

1. That he is the son of decedent Percy W. Spork, who died a resident of Lake County, Indiana, on May 13, 1997. A certified copy of the death certificate of Percy W. Spork is attached to this affidavit.

2. That he is the son of decedent Eva M. Spork, who died a resident of Lake County, Indiana, on April 7, 2003. A certified copy of the death certificate of Eva M. Spork is attached to this affidavit.

3. That Percy W. Spork and Eva M. Spork were the joint owners of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot 1 and the South 30 feet of Lot 2 in Block 1 in Greenlawn Addition to Hammond, as per plat thereof, recorded in Plat Book 17, page 28, in the Office of the Recorder of Lake County, Indiana, and the East 1/2 of the vacated alley lying West of and adjacent to said lots.

Commonly Known As: 7146 McCook Street, Hammond, IN 46323 (Tax Key #33-184-2)

ENTERED FOR TAXATION SUBJECT TO ACCEPTANCE FOR TRANSFER

MAY 5 2004

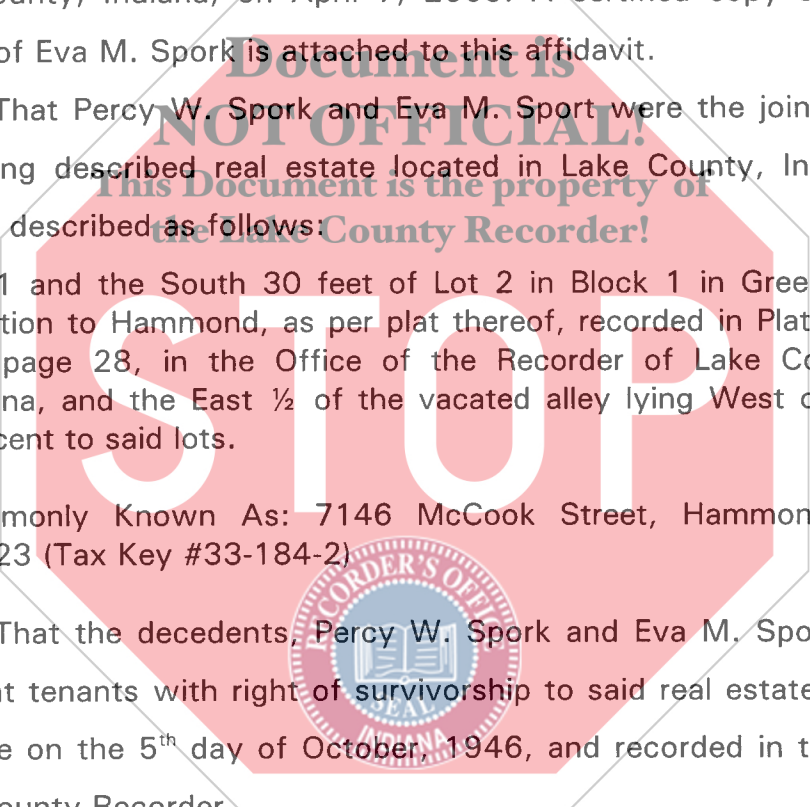
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

3. That the decedents, Percy W. Spork and Eva M. Spork, acquired title as joint tenants with right of survivorship to said real estate by deed of conveyance on the 5th day of October, 1946, and recorded in the Office of the Lake County Recorder.

4. That Percy W. Spork and Eva M. Spork jointly held title to said real estate as husband and wife until the death of Percy W. Spork on the 13th

TICOR TITLE INS.
HIGHLAND, INDIANA 920042045

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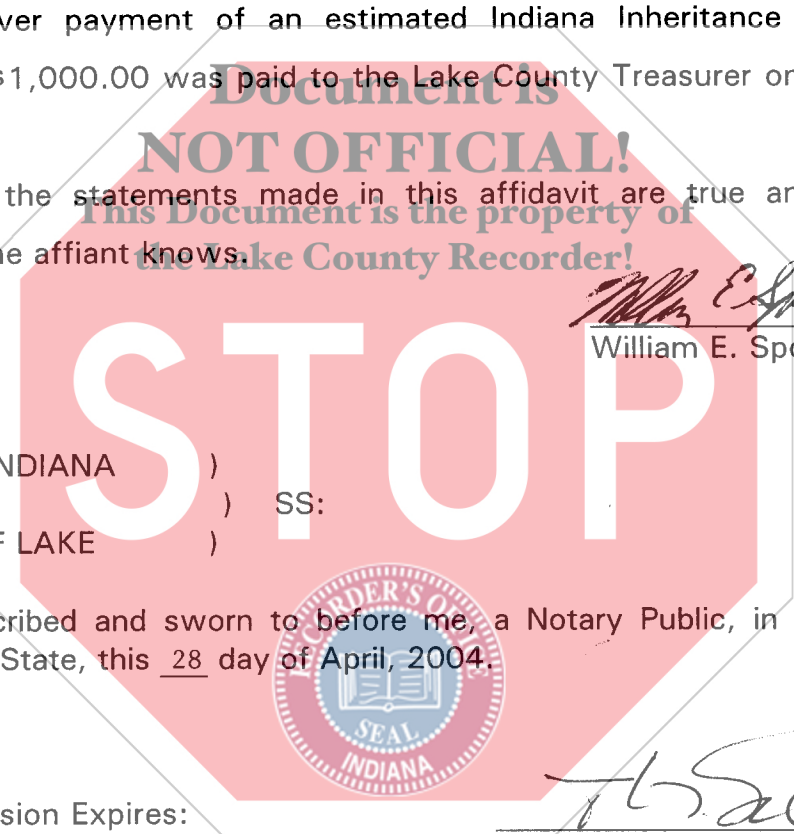
day of May, 1997, at which time title to the real estate vested in Eva M. Spork as the surviving joint tenant pursuant to property law.

5. The gross value of the estates of the decedents, Percy W. Spork and Eva M. Spork, as determined for the purpose of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return; therefore, the decedents' estates were not subject to Federal Estate Tax.

6. That the estate of decedent Percy W. Spork was not subject to Indiana Inheritance Tax.

7. That the estate of decedent Eva M. Spork is subject to Indiana Inheritance Tax. That an Indiana Inheritance Tax Return has not yet been filed, however payment of an estimated Indiana Inheritance Tax in the amount of \$1,000.00 was paid to the Lake County Treasurer on January 6, 2004.

That the statements made in this affidavit are true and complete insofar as the affiant knows.



[Signature]

William E. Spork

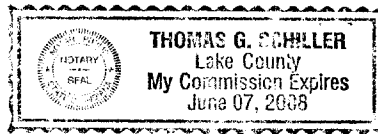
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Subscribed and sworn to before me, a Notary Public, in and for said County and State, this 28 day of April, 2004.

My Commission Expires:
June 07, 2008

[Signature]

, Notary Public



Prepared by William E. Spork

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INDIANA STATE DEPARTMENT OF HEALTH

* 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.

CERTIFICATE OF DEATH

Local No. 1012-97

State No.

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

203232
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) PERCY W. SPORK		2 SEX MALE	3a TIME OF DEATH 4:30 A.M.	3b DATE OF DEATH (Month, Day, Yr.) MAY 13, 1997	
4 *SOCIAL SECURITY NUMBER 306-01-8736	5a AGE—Last Birthday (Years) 84	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr.) JUNE 28, 1912	
7a WAS DECEDENT A U.S. VETERAN? no	7b YEAR LAST SERVED IN U.S. ARMED FORCES? no	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) THE COMMUNITY HOSPITAL		9c CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Eva M. Fraikin	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Stillman	12b KIND OF BUSINESS/INDUSTRY Atlantic-Richfield Sinclair		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hammond	13d STREET AND NUMBER 7146 McCook Avenue		
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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+) _____		18 FATHER'S NAME (First, Middle, Last) William Spork			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Ella Grimes		20a INFORMANT'S NAME (Type/Print) Mrs. Eva M. Spork			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7146 McCook Avenue Hammond, IN 46323		20c Relationship Wife			
21a METHOD OF DISPOSITION <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) May 16, 1997 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME David McCoy		22b EMBALMER'S LICENSE NO. FD08700581	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>John E. G... M.D.</i>		24b LICENSE NUMBER (of License) FD01013507	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323		
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) Metastatic Carcinoma of Prostate		DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death 3 years	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		DUE TO (OR AS A CONSEQUENCE OF)			
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I		DUE TO (OR AS A CONSEQUENCE OF)			
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>A. Gandhi</i>		29c MEDICAL LICENSE NO. 01029887	29d DATE SIGNED (Month, Day, Year) MAY 14, 1997		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) ARVIND GANDHI, M.D., 9122 COVINGTON AVENUE, MUNSTER, INDIANA 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. ... M.D.</i>		32 DATE FILED (Month, Day, Year) MAY 13, 1997			
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 APR 13, 2004
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

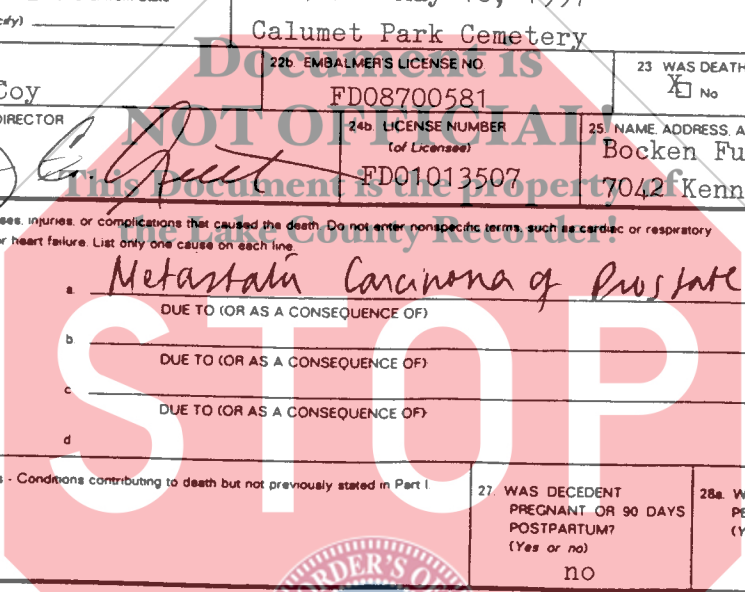
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



* 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.

10 TICOR - Highland 920042045
INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 887-03

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
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1 DECEASED—NAME (First Middle Last) EVA SPORK				2 SEX FEMALE	3a TIME OF DEATH 4:50 AM	3b DATE OF DEATH (Month Day Yr) APRIL 7, 2003	
4 *SOCIAL SECURITY NUMBER 315-10-2949		5a AGE—Last Birthday (Years) 87	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) FEB. 9, 1916	7 BIRTHPLACE (City and State or Foreign Country) Huntley, Illinois	
8a WAS DECEDENT A U.S. VETERAN? no	8b YEAR LAST SERVED IN U.S. ARMED FORCES? no	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence					
9b FACILITY NAME (If not institution, give street and number) Hartsfield Care Center				9c CITY TOWN OR LOCATION OF DEATH Munster		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) widowed		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) Homemaker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY TOWN OR LOCATION Hammond		13d STREET AND NUMBER 7146 McCook Avenue	
13e ZIP CODE 46323	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) Daniel Fraiken				19 MOTHER'S NAME (First Middle, Maiden Surname) Mary Dickens			
20a INFORMANT'S NAME (Type/Print) Mr. William Spork			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 Fran-Lin Parkway, Munster, IN 46321		20c Relationship Son		
21a METHOD OF DISPOSITION <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) April 9, 2003 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, IN		
22a EMBALMER'S NAME David F. McCoy			22b EMBALMER'S LICENSE NO. FDO8700581		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>George J. Bocken</i>			24b LICENSE NUMBER (of Licensee) FDO1042047		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH83002801 7042 Kennedy Ave. Hammond, IN 46323		
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 <i>Atherosclerotic cerebrovascular disease</i> > 1 yr				Approximate Interval Between Onset and Death	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b DUE TO (OR AS A CONSEQUENCE OF)					
		c DUE TO (OR AS A CONSEQUENCE OF)					
		d DUE TO (OR AS A CONSEQUENCE OF)					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Hypertension</i> <i>Atherosclerotic cardiovascular disease</i> <i>GASTRIC ulcers</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)							
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>Deanna Porte-Keene M.D.</i>					29c MEDICAL LICENSE NO. 01029185A	29d DATE SIGNED (Month, Day, Year) 4-7-2003	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Deanna Porte-Keene, M.D. 1650-45th Munster, IN 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best DO.</i>							
32 DATE FILED (Month, Day, Year) <i>April 8, 2003</i>							
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		
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.				