2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

TICOR TITLE INSURANCE

2004 048279

2004 JUN 9 AM

MORRIS W.
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

LOIS P. BEAWER, being first duly sworn upon oath, deposes and says:

1. That ROBERT E. BEAWER died on AUGUST 24, 2002, AD at HAMMOND, IN

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

LOT 12 AND THE NORTH 1/2 OF LOT 13 IN BLOCK 13 IN SUBDIVISION OF THE EAST PART OF THE NORTH SIDE ADDITION, TO THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 1, PAGE 97, 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.

Lois P. Beawer
LOIS P. BEAWER

Subscribed and sworn to before me, a Notary Public, this 1ST day of JUNE, 2004, AD.

Notary Public

FILED
JUN 8 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

My Commission expires:
MAY 16, 2009

CORINA CASTEL RAMOS
Lake County
My Commission Expires
May 16, 2009

County of Residence:
LAKE

This Instrument prepared by LOIS P. BEAWER

TICOR TITLE INSURANCE
2050-45TH AVE
HIGHLAND, IN 46322
92-4259D

000619

12 DC IN

* 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. 673

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.

Aug. 23, 2002 — Date Issued — Hammond Health Commissioner

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): ROBERT E. BEAWER
2. SEX: MALE
3a. TIME OF DEATH: 6:09 AM
3b. DATE OF DEATH (Month, Day, Yr.): AUGUST 24, 2002
4. *SOCIAL SECURITY NUMBER: 306-34-5900
5a. AGE—Last Birthday (Years): 65
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): DECEMBER 3, 1936
7. BIRTHPLACE (City and State or Foreign Country): CALUMET CITY, ILLINOIS
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1962
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
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): LOIS P. BAKOTA
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): OFFICE WORKER
12b. KIND OF BUSINESS/INDUSTRY: STEEL COMPANY
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 4625 CAMERON AVENUE
13e. ZIP CODE: 46327
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 BEAWER
19. MOTHER'S NAME (First, Middle, Maiden Surname): EMILY UNAVAILABLE

INFORMANT

20a. INFORMANT'S NAME (Type/Print): LOIS P. BEAWER
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4625 CAMERON AVE., HAMMOND, INDIANA 46327
20c. Relationship: WIFE

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): AUGUST 27, 2002 HOLY CROSS CEMETERY
21c. LOCATION—City or Town, State: CALUMET CITY, ILLINOIS
22a. EMBALMER'S NAME: KEITH D. ANTHONY
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327

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. MASSIVE CEREBROVASCULAR ACCIDENT — Approximate Interval Between Onset and Death: immediate
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: HYPERTENSION

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: [signature]
29c. MEDICAL LICENSE NO.: 01031445
29d. DATE SIGNED (Month, Day, Year): AUGUST 27, 2002
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M. HUSSAIN-SHAH M.D. 8032 KENNEDY AVENUE, HIGHLAND, INDIANA 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin J. Bermuda M.D
32. DATE FILED (Month, Day, Year): August 28, 2002

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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.

SDH06-004 State Form 10110 (R5/1-99)