

TICOR TITLE INSURANCE

2004 048279

2004 JUN 9 AM 10:10

MORRIS W. ...
RECORDED
AFFIDAVIT

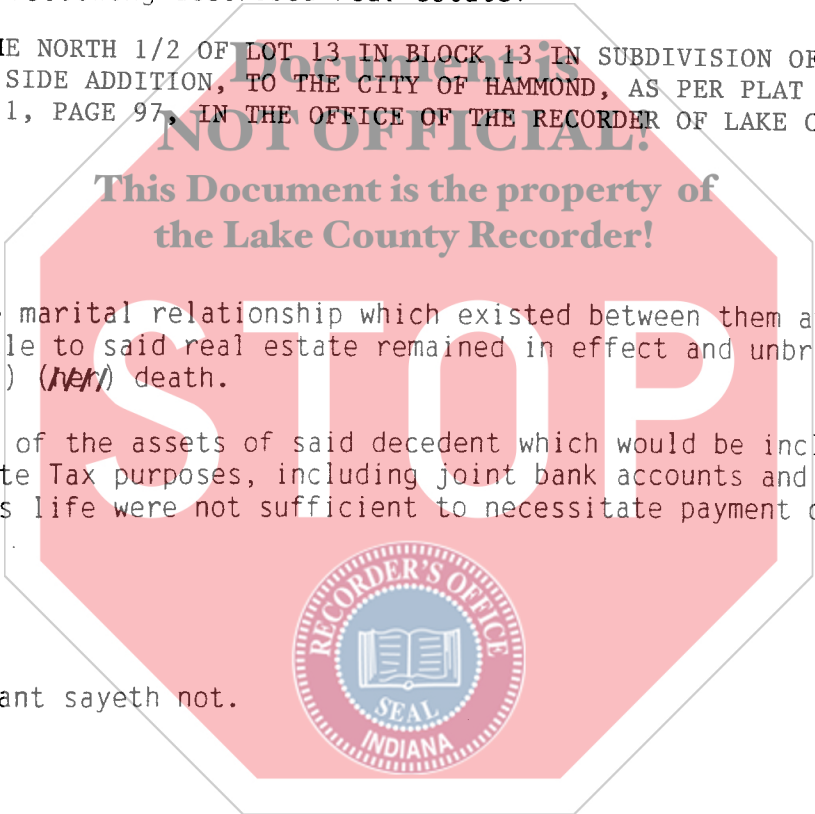
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

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

1. That ROBERT E. BEAWER died on
AUGUST 24, 2002, 10 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.

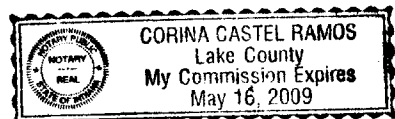
Lois P. Beawer
LOIS P. BEAWER

Subscribed and sworn to before me, a Notary Public, this 1ST day of
JUNE, 2004, 10/1.

FILED

JUN 8 2004

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR



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

Handwritten initials/signature

* 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 CERTIFICATE OF DEATH

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

Local No. 673

S Aug 23 2002
Date Issued Franklin J. Spemuda
Hammond Health Commissioner

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

| | | | | | | | | | | |
|--|--|--|--|---|---------------------|---|--|--|----------------------------------|--|
| 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: <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 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 <input type="checkbox"/> No <input checked="" 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+) | | | | 18. FATHER'S NAME (First, Middle, Last) CHARLES BEAWER | | | | |
| 19. MOTHER'S NAME (First, Middle, Maiden Surname) EMILY UNAVAILABLE | | | | 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 | |
| 21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | | | | |
| 24a. SIGNATURE OF FUNERAL DIRECTOR <i>Keith D Anthony</i> | | 24b. LICENSE NUMBER (of license) 01011911 | | 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327 | | | | | | |
| 26. PART I. Enter the disease, 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. MASSIVE CEREBROVASCULAR ACCIDENT 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 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 | | | | | | |
| 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>[Signature]</i> | | | | | | 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 | | | | | | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Spemuda M.D.</i> | | | | | | | | 32. DATE FILED (Month, Day, Year) August 28, 2002 | | |
| 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 | | | |
| 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. | | | | | | |

