

4



Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

2004 055204

On this 6-17-04 before me personally appeared _____
(insert date)

Billy R. PERDUE

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is OWNER
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Billy R. Perdue and LENORE J PERDUE

4. Said LENORE J. PERDUE
(fill in name of co-tenant who died)
died on 9-01-1999
leaving NO will;
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:

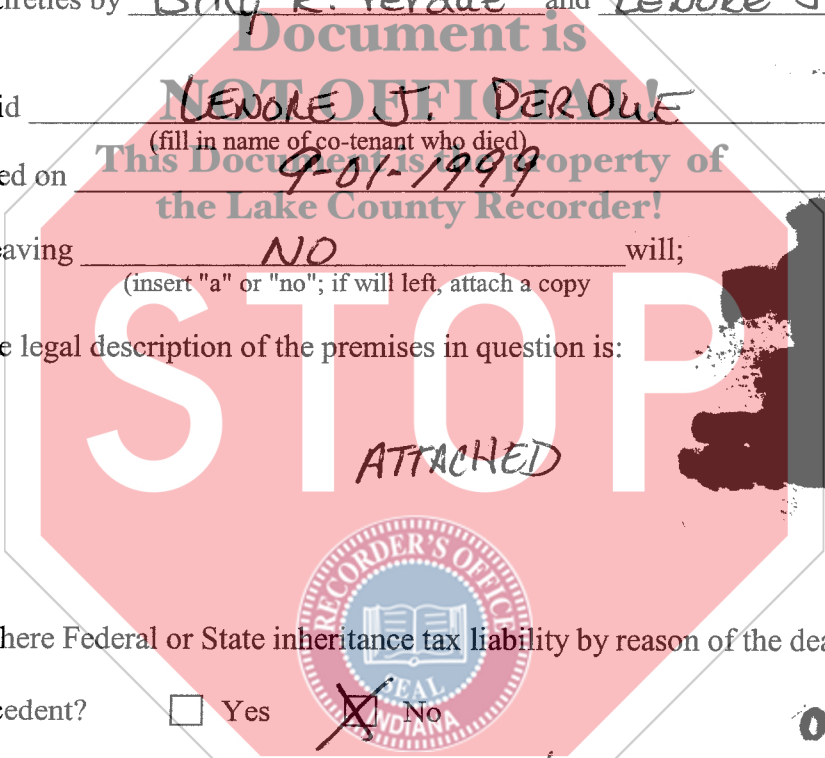
ATTACHED

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? Yes No

If yes, then estimated taxes due are \$ N/A

The taxes due are paid or unpaid..

SOUTHSHORE TITLE LLC 990040608



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2004 JUN 30 AM 9:20
MORRIS W. LAFFER
RECORDER

002302

SOUTHSHORE TITLE LLC
11055 BROADWAY
CROWN POINT, IN 46307

16-DC
SS

No: 40608SS

LEGAL DESCRIPTION

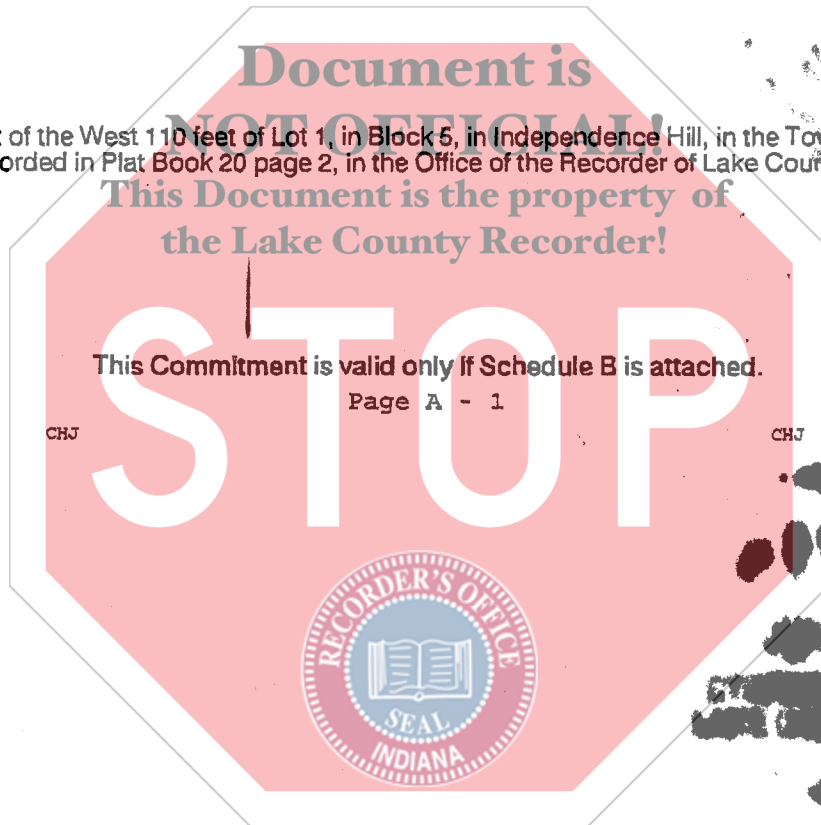
The land referred to in this Commitment is described as follows:

Parcel 1:

The West 55 feet of Lot 1 in Block 5, in Independence Hill, in the Town of Merrillville, as per plat thereof, recorded in Plat Book 20 page 2, in the Office of the Recorder of Lake County, Indiana..

Parcel 2:

The East 55 feet of the West 110 feet of Lot 1, in Block 5, in Independence Hill, in the Town of Merrillville, as per plat thereof, recorded in Plat Book 20 page 2, in the Office of the Recorder of Lake County, Indiana..



ACA 6/96

CHJ

CHJ

06/02/04

10:49:40

6cc

* 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

State No.

Local No. 2004-99

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

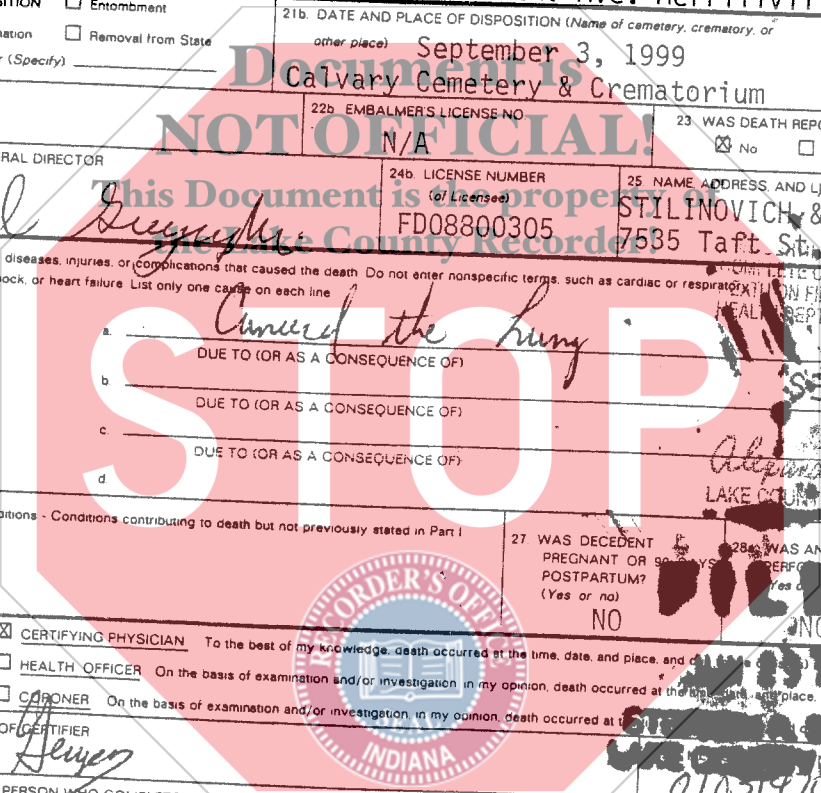
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) LENORE JANE PERDUE		2. SEX FEMALE	3a. TIME OF DEATH 12:30 P.M.	3b. DATE OF DEATH (Month, Day, Yr.) SEPTEMBER 1, 1999
4. *SOCIAL SECURITY NUMBER 315-48-5790	5a. AGE—Last Birthday (Years) 51	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo, Day, Yr.) October 9, 1947
7a. WAS DECEDENT A U.S. VETERAN? NO	7b. YEAR LAST SERVED IN U.S. ARMED FORCES? -	9. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) 2219 W. 79th. Ave.		9c. CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Bill Perdue	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). Bus Driver		12b. KIND OF BUSINESS/INDUSTRY School
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Merrillville		13d. STREET AND NUMBER 2219 W. 79th. Ave.
13e. ZIP CODE 46410	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 T. Jones		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Eleanor Collins		20. INFORMANT'S NAME (Type/Print) Bill Perdue		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2219 W. 79th. Ave. Merrillville, IN 46410		20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) September 3, 1999 Calvary Cemetery & Crematorium		21c. LOCATION—City or Town, State Portage, IN
22. EMBALMER'S NAME N/A		22b. EMBALMER'S LICENSE NO. N/A		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Leonard [Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD08800305	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME STILINOVICH & WIATROLIK FH83004455 7535 Taft St. Merrillville, IN 46410	
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. Caused the lung a. _____ DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____		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) as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> _____		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John George, M.D. 7905 Calumet Ave. Munster, IN 46321		31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Hillman, M.D.</i>		
32. DATE FILED (Month, Day, Year) September 3, 1999		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.		



FILED

SEP 03 1999