

3

  
**TICOR TITLE INSURANCE**

2004 093216

AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Noah J. Riffett, being first duly  
sworn upon oath, deposes and says:

1. That Noah J. Riffett  
August 7, 1999 at 1:30am
2. That Noah J. Riffett and Alice J. Riffett  
were duly and legally married at the time they acquired title as husband and  
wife to the following described real estate:

*See Attached*

**Document is  
NOT OFFICIAL!  
This Document is the property of  
the Lake County Recorder!**

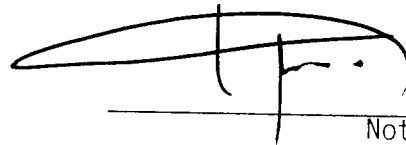
3. That the marital relationship which existed between them at the time they  
acquired title to said real estate remained in effect and unbroken until the  
date of (his) (her) death.
4. That all of the assets of said decedent which would be includable for  
Federal Estate Tax purposes, including joint bank accounts and life insurance  
on decedent's life were not sufficient to necessitate payment of Federal Estate  
Tax.

Further affiant sayeth not.

DULY ENTERED FOR TAXATION SUBJECT TO  
FINAL ACCEPTANCE FOR TRANSFER

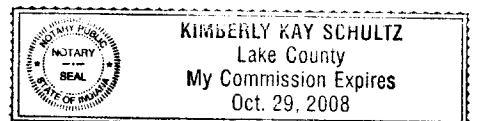
Subscribed and sworn to before me, a Notary Public, this  
October, ~~2004~~.

*Alice J. Riffett*  
NOV 4 2004  
STEPHEN R. SHELICH  
LAKE COUNTY AUDITOR

  
Notary Public

My Commission expires:

County of Residence:



This Instrument prepared by Alice J. Riffett **000024**

TICOR TITLE INSURANCE  
11055 BROADWAY SUITE A  
CROWN POINT, INDIANA 46307  
920047124

14-DC  
17

\* 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. 1817-99

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

396126  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

|   |  |   |   |   |  |   |  |  |  |  |
|---|--|---|---|---|--|---|--|--|--|--|
| 1 DECEASED—NAME (First, Middle, Last)<br><b>Noah J. Riffett</b>   |  |   | 2 SEX<br><b>Male</b>  |   | 3a TIME OF DEATH<br><b>1:30A M</b>   |   | 3b DATE OF DEATH (Month, Day, Yr)<br><b>August 7, 1999</b> |  |  |  |
| 4 *SOCIAL SECURITY NUMBER<br><b>234-48-0348</b>   |  | 5a AGE—Last Birthday (Years)<br><b>70</b>   |   | 5b UNDER 1 YEAR<br>Months Days  |  | 5c UNDER 1 DAY<br>Hours Minutes   |  | 6 DATE OF BIRTH (Mo, Day, Yr)<br><b>Aug. 30, 1928</b>                |  |  |
| 8a WAS DECEDENT A U.S. VETERAN?<br><b>No</b>  |  | 8b YEAR LAST SERVED IN U.S. ARMED FORCES?<br><b>None</b>                                      |   | 9a PLACE OF DEATH (Check only one. See instructions)<br>HOSPITAL <input checked="" type="checkbox"/> Inpatient<br><input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Residence |  |   |  |  | 7 BIRTHPLACE (City and State or Foreign Country)<br><b>Harts, WV</b> |  |
| 9b FACILITY NAME (If not institution, give street and number)<br><b>St. Mary Medical Center</b>   |  |   |   |   | 9c CITY, TOWN OR LOCATION OF DEATH<br><b>Hobart</b>  |   |  | 9d COUNTY OF DEATH<br><b>Lake</b>                                    |  |  |
| 10 MARITAL STATUS (Specify)<br><b>Married</b>   |  | 11 SURVIVING SPOUSE (If wife, give maiden name)<br><b>Alice Moore</b>                         |   | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br><b>Welder</b>   |  |   | 12b KIND OF BUSINESS/INDUSTRY<br><b>U.S. Steel</b>         |  |  |  |
| 13a RESIDENCE—STATE<br><b>IN</b>  |  | 13b COUNTY<br><b>Lake</b>   |   | 13c CITY, TOWN, OR LOCATION<br><b>Crown Point</b>   |  |   | 13d STREET AND NUMBER<br><b>1535 Morningside Ct.</b>       |  |  |  |
| 13e ZIP CODE<br><b>46307</b>  |  | 13f INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes |   | 14 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 15 WAS DECEDENT OF HISPANIC ORIGIN?<br><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)<br><b>White</b> |  |  |
| 17 DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b>   |  | 18 FATHER'S NAME (First, Middle, Last)<br><b>James Riffett</b>                                |   | 19 MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Betty Watts</b>  |  |   |  |  |  |  |
| 20a INFORMANT'S NAME (Type/Print)<br><b>Alice Riffett</b>   |  |   | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1535 Morningside Ct. Crown Point, IN</b> |   |  |   |  | 20c Relationship<br><b>Wife</b>                                      |  |  |
| 21a METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>August 12, 1999<br/>Pack Cemetery</b>                 |   |  |   |  | 21c LOCATION—City or Town, State<br><b>Little Harts, WV</b>          |  |  |
| 22a EMBALMER'S NAME<br><b>John T. Noble</b>   |  |   | 22b EMBALMER'S LICENSE NO.<br><b>9000031</b>  |   | 23 WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                           |   |  |  |  |  |
| 24a SIGNATURE OF FUNERAL DIRECTOR<br><i>[Signature]</i>   |  |   | 24b LICENSE NUMBER (of Licensee)<br><b>1021590</b>  |   | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br><b>Burns-Kish Funeral Home #3004968<br/>8415 Calumet MUnster, IN 46321</b> |   |  |  |  |  |
| 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.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death)<br>a. <b>Pulmonary emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF)<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF)<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF)<br>d.<br>Approximate interval Between Onset and Death<br><b>Yes</b>  |  |   |   |   |  |   |  |  |  |  |
| 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)<br><b>NO</b>  |  |   | 28a WAS AN AUTOPSY PERFORMED? (Yes or no)<br><b>NO</b>  |   |  | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)<br><b>--</b>   |  |  |  |  |
| 29a CERTIFIER (Check only one)<br><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<br><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<br><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<br><b>R. Devanathan</b>  |  |   |   |   |  | 29c MEDICAL LICENSE NO.<br><b>IN 01040141</b>   |  | 29d DATE SIGNED (Month, Day, Year)<br><b>aug. 9, 1999</b>            |  |  |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print)<br><b>Raja Devanathan, M.D., 1600 S. Lake Park Ave #1104 Hobart, IN</b>  |  |   |   |   |  |   |  |  |  |  |
| 31 HEALTH OFFICER'S SIGNATURE<br><i>Alexander Williams, M.D.</i>  |  |   |   |   |  |   | 32 DATE FILED (Month, Day, Year)<br><b>August 9, 1999</b>  |  |  |  |
| 33 MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined<br><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.   |   |  |   |  |  |  |  |

No: 920047124

### LEGAL DESCRIPTION

Lot 157 in Harvest Manor Unit No. 1, Section No. 5, an Addition to the Town of Schererville, as per plat thereof, recorded in Plat Book 72 page 5, in the Office of the Recorder of Lake County, Indiana.

Key # 20-13-54a-13

