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original

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 094771

2004 NOV -5 AM 10:27

Order No.: 966711

MORRIS W. STIGLICH
RECORDER

LEGAL DESCRIPTION:

Lot 27, Block 11, Smith and Bader's 2nd West Park Addition to Hammond as shown in Plat Book 15, page 9, in Lake County, Indiana.

PROPERTY ADDRESS:

2013 Calumet Avenue, Hammond, IN 46394

ESTATE AFFIDAVIT

, Affiant, states that: Emma Jean Horne

1. , deceased, died on the . 6/25/04

2. Affiant is: [] the surviving spouse of the deceased.

the Personal Representative/Executor-trix of the estate of the deceased.

3. The deceased died: leaving a will which has been probated.

[] leaving a will which has not been probated.

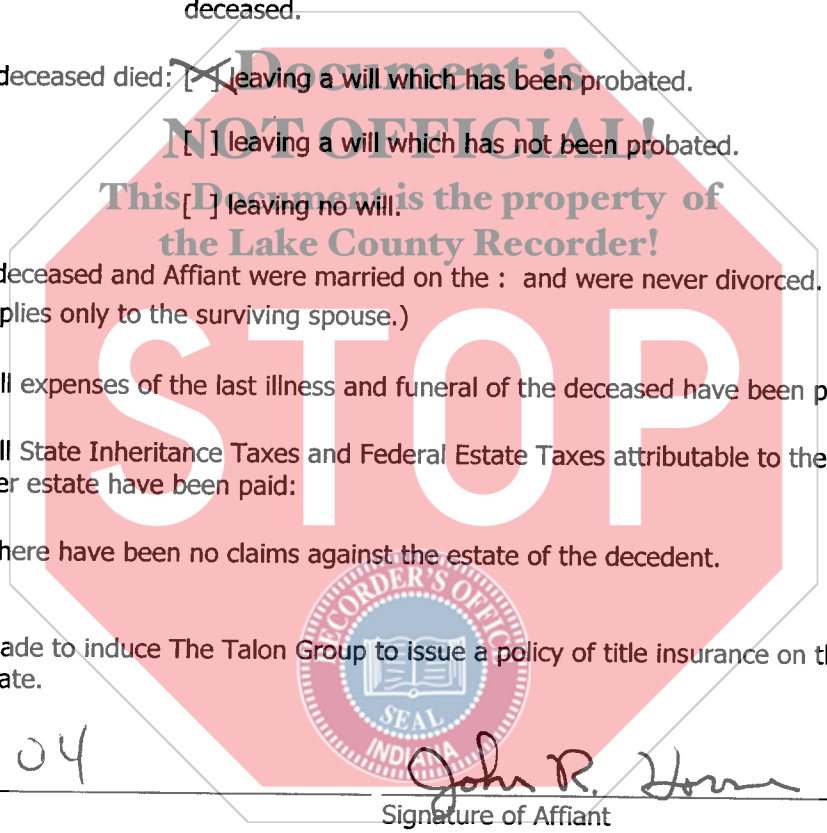
[] leaving no will.

4. The deceased and Affiant were married on the : and were never divorced.
(This item applies only to the surviving spouse.)

5. All expenses of the last illness and funeral of the deceased have been paid:

6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid:

7. There have been no claims against the estate of the decedent.



This Affidavit is made to induce The Talon Group to issue a policy of title insurance on the above-described real estate.

11-1-04
Date

John R. Horne
Signature of Affiant

John R. Horne
Printed Name of Affiant

DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER

NOV 5 2004

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

HOLD FOR THE TALON GROUP

966711

13
TJG
TGG

000529

State of Indiana. County of Lake

Subscribed and sworn to before me this 1st day of November, 2004.

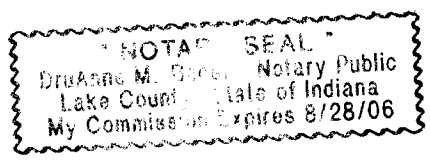
DruAnne M. Bacon

Notary Public

Printed Name _____

Resident of _____ County

My Commission Expires: _____



THIS INSTRUMENT WAS PREPARED BY: J Horne



ATTENTION: The Social Security # is being requested by this state agency in order to sue 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. 15-73-041

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

PE/PRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANT

DISPOSITION

USE OF

ATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) EMMA JEAN HORNE				2 SEX F		3a TIME OF DEATH 3:35 PM		3b DATE OF DEATH (Month Day Yr) JUNE 25, 2004					
4 *SOCIAL SECURITY NUMBER 408-30-1899		5a AGE—Last Birthday (Years) 78		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo Day Yr) JANUARY 16, 1926		7 BIRTHPLACE (City and State or Foreign Country) KNOXVILLE TN			
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		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) Community Hospital						9c CITY TOWN OR LOCATION OF DEATH MUNSTER			9d COUNTY OF DEATH LAKE				
10 MARITAL STATUS (Specify) WIDOW		11 SURVIVING SPOUSE (If wife, give maiden name) N/A		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) WEAVER				12b KIND OF BUSINESS/INDUSTRY REXNORD					
13a RESIDENCE—STATE IN		13b COUNTY LAKE		13c CITY TOWN OR LOCATION CEDER LAKE			13d STREET AND NUMBER 13182 PARRISH						
13e ZIP CODE 46303		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) W		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) MADISON ARNOLD						19 MOTHER'S NAME (First, Middle, Maiden Surname) ROBY							
20a INFORMANT'S NAME (Type/Print) JOHN HORNE				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8614 CHRISTOPHER DR ST. JOHN, IN				20c Relationship SON					
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) JUNE 29, 2004 MEMORY LAKE				21c LOCATION—City or Town, State Schererville IN					
22a EMBALMER'S NAME Thomas Owens				22b EMBALMER'S LICENSE NO. 1001049		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas Owens</i>				24b LICENSE NUMBER (of Licensee) 1001049		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME OWENS FH 816-119TH WHITING IN 46394							
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. Intracranial Bleed										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) a _____ DUE TO (OR AS A CONSEQUENCE OF)													
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						27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a WAS AN AUTOPSY PERFORMED? (Yes or 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>[Signature]</i>						29c MEDICAL LICENSE NO. 01031764		29d DATE SIGNED (Month, Day, Year) 6-25-04					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. P. Alakum 9126 Columbia Ave Munster, IN 46321													
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32 DATE FILED (Month, Day, Year) JUN 28 2004							
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 DEATH ON FIFTH FLOOR					
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) JUN 28 2004							
34g DATE PRONOUNCED DEAD (Month, Day, Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.									