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original

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 094771

2004 NOV -5 AM 10:37

MORRIS W. ...EP
RECORDER

Order No.: 966711

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.

[X] the Personal Representative/Executor-trix of the estate of the deceased.

3. The deceased died: [X] 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. [X] All expenses of the last illness and funeral of the deceased have been paid:

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

7. [X] 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

96671

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

NOV 5 2004

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

HOLD FOR THE TALON GROUP

96671

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TG

529

State of Indiana. County of Lake

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

Notary Public

Printed Name

Resident of _____ County

My Commission Expires:

_____

NOTARY SEAL
DruAnne M. Booth Notary Public
Lake County, State of Indiana
My Commission Expires 8/28/06

THIS INSTRUMENT WAS PREPARED BY: J Horne.

TTENTION ESTATE: The Social Security # is ng requested by this state agency in order to sue its statutory responsibility. Disclosure is untary and there will be no penalty for refusal

cal No. 15-73-04

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

PE/PRINT IN RMANENT LACK INK

CEDENT

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 11, 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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] 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): Weider
12b KIND OF BUSINESS/INDUSTRY: Rexnord
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Cedar Lake
13d STREET AND NUMBER: 13182 Parrish
13e ZIP CODE: 46303
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): W
17 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):

RENTS

18 FATHER'S NAME (First, Middle, Last): Madison Arnold
19 MOTHER'S NAME (First, Middle, Maiden Surname): Ruby

ORMANT

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

SPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 29, 2004 Memory Lane
21c LOCATION—City or Town, State: Schererville IN
22a EMBALMER'S NAME: Thomas Owens
22b EMBALMER'S LICENSE NO: FEC1049
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Thos Owens
24b LICENSE NUMBER (of Licensee): 100049
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: 3007291 Owens F.H. 816-119th Whiting IN 46394

USE OF ATH

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Intracranial Bleed
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

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):

RTIFIER

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: 01031764
29d DATE SIGNED (Month, Day, Year): 6-28-04
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Dr P Nakum 912 Columbia Ave Munster, IN 46321

ALTH FICER

31 HEALTH OFFICER'S SIGNATURE: [signature] D.O.
32 DATE FILED (Month, Day, Year): JUL 1, 2004

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