


TICOR TITLE INSURANCE

2004 094973

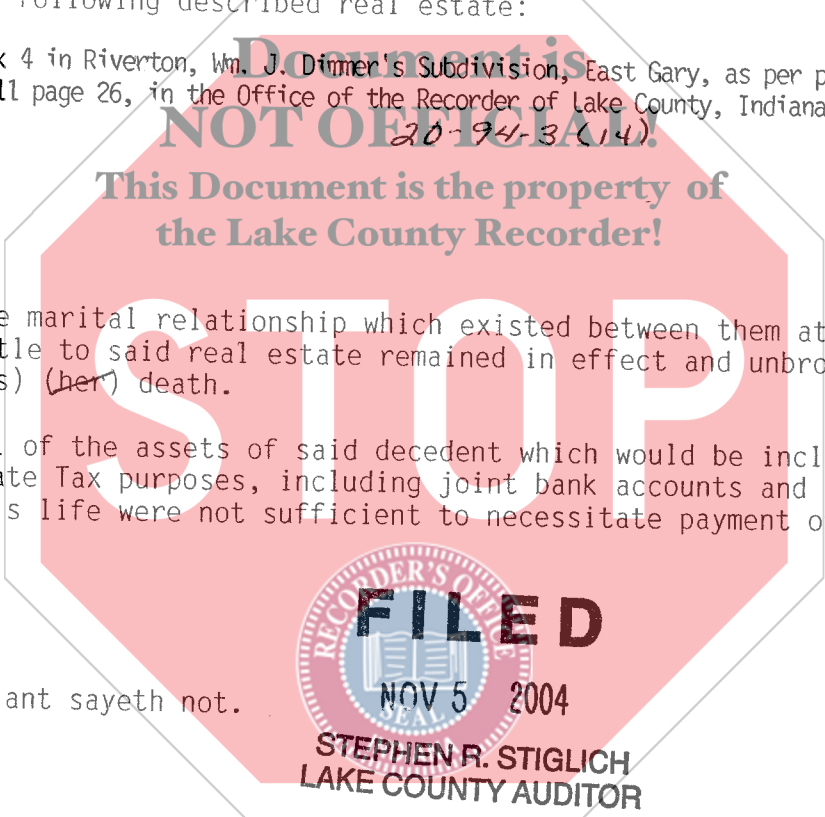
AFFIDAVIT

STATE OF INDIANA)
 COUNTY OF LAKE) SS:

Lucille Viar, being first duly sworn upon oath, deposes and says:

1. That Morgan Viar September 28, 1991 at Lake Station, IN.
2. That Morgan Viar and Lucille Viar were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 3 in Block 4 in Riverton, Wm. J. Dimer's Subdivision, East Gary, as per plat thereof, recorded in Plat Book 11 page 26, 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.

Lucille Viar
 Lucille Viar

Subscribed and sworn to before me, a Notary Public, this 27th day of October, ~~18~~ 2004.

Kathy C. Cunningham
 Kathy C. Cunningham Notary Public

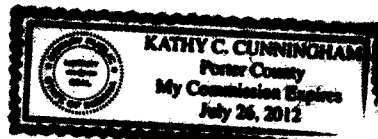
My Commission expires: 07/26/12

Porter

County of Residence:

Porter

This Instrument prepared by Dennis Viar



000499

125977

TICOR TITLE INS. 111 W. 10TH ST. - STE. 201 HOBART, IN 46342
 020047709
 Wanzel

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD NOV 8 2004 MORRIS REC'D

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 2004-91

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) JAMES MORGAN VIAR		2 SEX MALE	3a TIME OF DEATH 2:15 P	3b DATE OF DEATH (Month, Day, Yr) SEPTEMBER 28, 1991	
4 SOCIAL SECURITY NUMBER 408-30-7066	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) SEPT. 6, 1918	
7 BIRTHPLACE (City and State or Foreign Country) DYERSBURG, TENNESSEE	8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) 2213 RIVERSIDE		9c CITY, TOWN, OR LOCATION OF DEATH LAKE STAION	9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) MABLE LUCILLE TILFORD	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) MILLWRIGHT	12b KIND OF BUSINESS/INDUSTRY U S STEEL-GARY WORKS		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN, OR LOCATION LAKE STATION	13d STREET AND NUMBER 2213 RIVERSIDE DRIVE		
13e ZIP CODE 46405	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? 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) N/A College (1-4 or 5+) N/A		18 FATHER'S NAME (First, Middle, Last) GLENN ANDREW VIAR			
19 MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE ETHEL SURATT		20a INFORMANT'S NAME (Type/Print) MABLE LUCILLE VIAR			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 RIVERSIDE DRIVE, LAKE STATION, IN. 46450		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) OCTOBER 1, 1991 EVERGREEN MEMORIAL PARK CEMETERY		21c LOCATION—City or Town, State HOBART, INDIANA	
22a EMBALMER'S NAME JAMES F. BURNS		22b EMBALMER'S LICENSE NO. 1009461	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b LICENSE NUMBER (of Licensee) 1009461	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS' FUNERAL HOME FDH# 83002380 701 E. 7th STREET, HOBART, IN. 46342		
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Carcinomatosis DUE TO (OR AS A CONSEQUENCE OF) b. Adenocarcinoma of the Pancreas DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.				Approximate Interval Between Onset and Death	
PART II Other significant conditions contributing to death but not previously stated in Part I. Arterial 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>Alexander S. Williams, MD</i> LAKE COUNTY HEALTH COMMISSIONER		29c. MEDICAL LICENSE NO. 01017905	29d. DATE SIGNED (Month, Day, Year) 9-30-91		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) R. A. PENN, M. D., 3829 CENTRAL, LAKE STATION, INDIANA 46405 (962-1325)					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>				32 DATE FILED (Month, Day, Year) October 1, 1991	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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.			

File Copy

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

