2

TICOR TITLE INSURANCE

2004 094973

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2004 NOV -8 AM 9:
MORRIS W. CARTER
RECORDER

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

1. That Morgan Viar died on 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. Dimmer'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.
20-94-3(14)

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.

FILED
NOV 5 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Further affiant sayeth not.

Lucille Viar
Lucille Viar

Subscribed and sworn to before me, a Notary Public, this 27th day of October, ~~19~~ 2004.

Kathy C. Cunningham
Kathy C. Cunningham Notary Public

My Commission expires: 07/26/12

Porter

County of Residence:

Porter

KATHY C. CUNNINGHAM
Porter County
My Commission Expires
July 26, 2012

This Instrument prepared by Dennis Viar

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

92004709
Wanzer

000499

12.50 TK

5 CC's

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 2004-91 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JAMES MORGAN VIAR
2. SEX: MALE
3a. TIME OF DEATH: 2:15 P M
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): OVERSBURNG, 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: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ 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: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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

PARENTS

18. FATHER'S NAME (First, Middle, Last): GLENN ANDREW VIAR
19. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE ETHEL SURATT

INFORMANT

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

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ 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? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F. Burns
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

CAUSE OF DEATH

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. 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:
DUE TO (OR AS A CONSEQUENCE OF):

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

PART II. Other significant conditions. 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

CERTIFIER

29a. CERTIFIER (Check only one):
☒ 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: Alexander F. Williams, MD LAKE COUNTY HEALTH COMMISSIONER
29c. MEDICAL LICENSE NO.: 01017905
29d. DATE SIGNED (Month, Day, Year): 9-30-91

HEALTH OFFICER

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: Alexander F. Williams, MD
32. DATE FILED (Month, Day, Year): October 1, 199

CORONER USE ONLY

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.