2

TICOR TITLE INSURANCE

2004 091984

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Nancy J. Bailey, being first duly sworn upon oath, deposes and says:

1. That Jason L. Bailey died on September 13, ~~19~~ 2003 at St Margaret's Hospital

2. That Jason L. Bailey and Nancy J. Bailey were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
Lot 10 in Smith and Bader's Subdivision, as per plat thereof, recorded in Plat Book 3 page 93, in the Office of the Recorder of Lake County, Indiana.
29-99-10 (28)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2004 NOV 15 AM 9:16
MORRIS
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) ~~xxx~~ 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.

Nancy J. Bailey
Nancy J. Bailey

Subscribed and sworn to before me, a Notary Public, this 2nd day of Nov., 19/2004.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
NOV 5 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Corina Castel Ramos
Notary Public

My Commission expires:
5/16/09

County of Residence:
Lake

This Instrument prepared by Nancy J. Bailey

TICOR TITLE INS.
HIGHLAND, INDIANA
92004793 7
Wellcz KO

000492

12 DC

* **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.

Local No. 708

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Sept 15, 2003 — Date Issued — Hammond Health Commissioner

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): JASON L. BAILEY
2. SEX: MALE
3a. TIME OF DEATH: 12:20P M
3b. DATE OF DEATH (Month, Day, Yr.): SEPTEMBER 13, 2003
4. *SOCIAL SECURITY NUMBER: 234-56-1592
5a. AGE—Last Birthday (Years): 67
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): APR. 24, 1936
7. BIRTHPLACE (City and State or Foreign Country): MALLORY, W. VIRGINIA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1958
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARGARET MERCY HEALTHCARE CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): NANCY J. BONNER
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): WELDER
12b. KIND OF BUSINESS/INDUSTRY: LTV STEEL CO.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: WHITING
13d. STREET AND NUMBER: 2039 NEW YORK AVENUE
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: XX 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): 8; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): RICHARD BAILEY
19. MOTHER'S NAME (First, Middle, Maiden Surname): MYRLIE HARLISS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MRS. NANCY J. BAILEY
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2039 NEW YORK, WHITING, IN 46394
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEPTEMBER 17, 2003 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, IND.
22a. EMBALMER'S NAME: HENRY J. BLAKE
22b. EMBALMER'S LICENSE NO.: FDE01019406
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Intracerebral hemorrhage
DUE TO (OR AS A CONSEQUENCE OF)
b. Hypertension
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

Approximate Interval Between Onset and Death

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): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

FILED
NOV 5 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

TICOR TITLE INS.
HIGHLAND, INDIANA
92004 7937
Welicky

CERTIFIER

29a. CERTIFIER (Check only one)
XX 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: James B. Walsh
29c. MEDICAL LICENSE NO.: 01027487
29d. DATE SIGNED (Month, Day, Year): SEPT. 15, 2003
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JAMES B. WALSH, M.D., 5500 HOHMAN AVENUE, HAMMOND, INDIANA 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Suemuda M.D.
32. DATE FILED (Month, Day, Year): September 15, 2003

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

000493