2

SAME NAME AFFIDAVIT

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

6200533588 2005 046487

2005 JUN -7 AM 10:22

This is to certify that I, ~~Abraham Brooks~~

MICHAEL A. BROWN
RECORDER

am one and the same person as Abble Brooks who

holds title to the real estate described in Exhibit A attached hereto.

Affiant further sayeth not.

Signature ~~Abraham Brooks~~

Printed Name Abraham Brooks

State of Indiana
SS:
County of LAKE

Before me, the undersigned, a Notary Public, personally appeared the affiant, and, being duly sworn by me upon oath, says that the facts alleged in the foregoing instrument are true.
Signed, sealed, and delivered this 24th day of May, 2005.

Signature Mary D Barnes

Printed MARY D. BARNES

My County of Residence LAKE

My commission expires: 10/02/06

This affidavit was prepared by Mercantile National Bank / M. Waechter

12-2 CT

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 02 0204 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Mary Brooks
2. SEX: Female
3a. TIME OF DEATH: 9:15a M
3b. DATE OF DEATH (Month, Day, Yr.): March 17, 2002
4. *SOCIAL SECURITY NUMBER: 307-22-4976
5a. AGE—Last Birthday (Years): 85
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr.): November 29 1916
7. BIRTHPLACE (City and State or Foreign Country): RULEVILLE, MS.
8a. WAS DECEDENT A U.S. VETERAN? N/A
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
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): Timberview Rehab. Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Gary
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Abbie Brooks
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)
12b. KIND OF BUSINESS/INDUSTRY
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 1165 Wallace St.
13e. ZIP CODE: 46404
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last): Robert Berry
19. MOTHER'S NAME (First, Middle, Maiden Surname): Georgia N/A

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Abbie Brooks AKA Abraham Brooks
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1165 Wallace St. Gary In. 46404
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): MARCH 23, 2002 FERN OAK CEMETERY
21c. LOCATION—City or Town, State: Griffin, In
22a. EMBALMER'S NAME: Leon Coleman Jr.
22b. EMBALMER'S LICENSE NO: 4523
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Leon Cs
24b. LICENSE NUMBER (of Licensee): 104-5231
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Powell-Coleman Funeral Home 1901 Washington St. Gary In. 88602434

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. Hepatic Failure — 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

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): 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: D.E. Ross M.D
29c. MEDICAL LICENSE NO: 0101 [illegible] 89
29d. DATE SIGNED (Month, Day, Year): 3-22-02
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): David E Ross MD 1619 W 5th Ave Gary In 46404

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): MAR 22 2002

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.

SDH06-004 State Form 10110 (R4/3-02) Deathcer/PD 1