

Att: Tami



TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Lawrence A. Hurley, Jr., being first, duly sworn upon oath, deposes and says:

1. That Carol G. Hurley died on August 20, 2002 at Monster Community Hospital
2. That Lawrence A. Hurley, Jr. and Carol G. Hurley held title as tenants by the entireties for the following real estate:

Lot 13 in Rubrights Subdivision, as per plat thereof, recorded in Plat Book 32 page 74, 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 funeral expenses in connection with the death of said decedent have been paid in full.

5. 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.

Subscribed and sworn to before me, a Notary Public, this 3rd day of June 2005.

Lawrence A. Hurley, Jr.
Lawrence A. Hurley, Jr.

Beth Embry
Beth Embry Notary Public

My Commission expires:

12/18/06

County of Residence:

Stephens County, Georgia

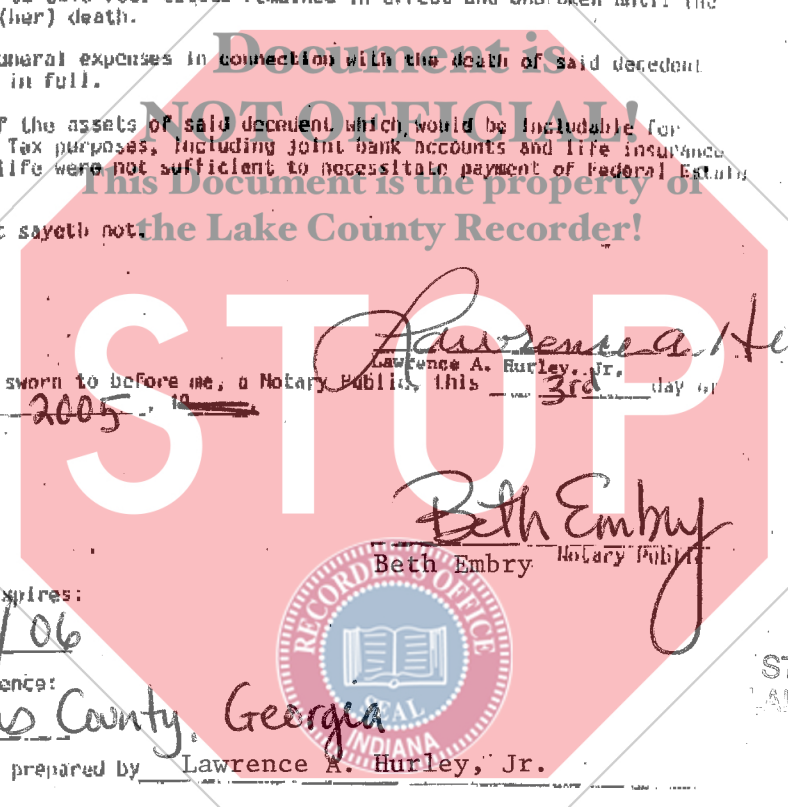
This instrument prepared by Lawrence A. Hurley, Jr.

2005 048728

2005 JUN 14 AM 8:25

MICHAEL A. JAMES
RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD



FILED

JUN 13 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

TICOR SO

TOTAL P.02

31027

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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to insure its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. IND-02

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) CAROL G. HURLEY				2 SEX FEMALE		3a TIME OF DEATH 4:45 A M		3b DATE OF DEATH (Month, Day, Yr) AUGUST 20, 2002					
4 *SOCIAL SECURITY NUMBER 204-22-1388		5a AGE—Last Birthday (Years) 71		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) OCT. 4, 1930		7 BIRTHPLACE (City and State or Foreign Country) SWICKLEY, PENNSYLVANIA			
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 checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> 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) MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) LAWRENCE A. HURLEY JR.			12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) HOMEMAKER			12b KIND OF BUSINESS/INDUSTRY DOMESTIC					
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY TOWN OR LOCATION DYER			13d STREET AND NUMBER 12013 W. 79th. PL.						
13e ZIP CODE 46311		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 12 College (1-4 or 5+) 12			
18 FATHER'S NAME (First, Middle, Last) ANDREW GREER					19 MOTHER'S NAME (First, Middle, Maiden Surname) OLIVE EWING								
20a INFORMANT'S NAME (Type/Print) LAWRENCE A. HURLEY JR.				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12013 W. 79th. PL. DYER, IND. 46311				20c Relationship HUSBAND					
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" 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) AUGUST 22, 2002 N.W. IND. CREMATION SERVICE				21c LOCATION—City or Town, State CROWN POINT, INDIANA					
22a EMBALMER'S NAME ELI VUJKO				22b EMBALMER'S LICENSE NO. FDO1008300		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a SIGNATURE OF FUNERAL DIRECTOR				24b LICENSE NUMBER FDO1008300		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307							
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 <u>Metastatic Melanoma</u> b <u>Metastatic Melanoma</u> c <u>Metastatic Melanoma</u> d <u>Metastatic Melanoma</u> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last										Approximate Interval Between Onset and Death 8 months			
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)				
29a CERTIFIER (Check only one) <input 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 <u>[Signature]</u>						29c MEDICAL LICENSE NO. 01000106		29d DATE SIGNED (Month, Day, Year) 8-20-02					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) J. JANO, M.D. 7905 CALUMET AVE., MUNSTER, IN 46321													
31 HEALTH OFFICER'S SIGNATURE <u>[Signature]</u>										32 DATE FILED (Month, Day, Year) AUG 21, 2002			
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 PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) AUG 20, 2002						34d OCCUPATION (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.									