

3

DECEASED JOINT TENANT AFFIDAVIT

State of Indiana )  
County of LAKE ) SS

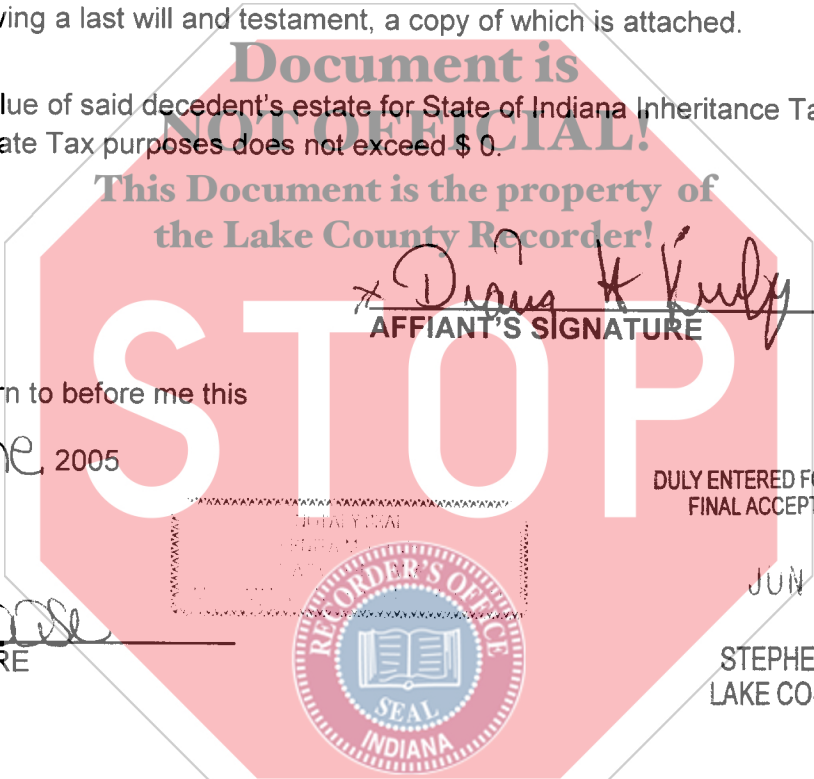
Date: 6/17/05  
File: 05000637

DIANA H. KIRBY, being first duly sworn, for the purpose of inducing Residential Title Services, Inc. to issue its title insurance policy covering the land described in the above captioned commitment, deposes and says;

- 1. That he/she resides at: 3253 KENWOOD ST. HAMMOND, IN 46320<sup>2</sup>
- 2. That he/she was acquainted with **THOMAS TIM KIRBY** who died on 11/17/04 as evidence by the attached certified copy of the death certificate.
- 3. That said decedent was one of the owners of the land described in the above captioned commitment.
- 4. That said decedent died:  
 leaving no will and last testament.  
 leaving a last will and testament, a copy of which is attached.

- 5. That the total value of said decedent's estate for State of Indiana Inheritance Tax/Estate Tax and Federal Estate Tax purposes does not exceed \$ 0.

2005 052406



Subscribed and sworn to before me this  
17 day of June 2005

[Signature]  
NOTARY SIGNATURE

[Signature]  
AFFIANT'S SIGNATURE

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

JUN 24 2005

STEPHEN R. STIGLICH  
LAKE COUNTY AUDITOR

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

After Recording Return to: DIANA H. KIRBY 3253 KENWOOD ST. HAMMOND, IN 46320  
This Document was Prepared By: DIANA H. KIRBY

002036\*

14/0  
CHK# 5767  
CP

5cc + 2vet

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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.  
Date Issued: 11/22/2004  
Hammond Health Commissioner

Local No. 783

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED-NAME (First, Middle, Last) <b>Thomas Tim Kirby</b>				2. SEX <b>Male</b>		3a. TIME OF DEATH <b>10:55 PM</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>November 17, 2004</b>	
4. SOCIAL SECURITY NUMBER <b>308-38-1128</b>		5a. AGE-Last Birthday (Years) <b>66</b>		5b. UNDER 1 YEAR Months: Days		5c. UNDER 1 DAY Hours: Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) <b>February 17, 1938</b>	
6a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1961</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Terre Haute, IN</b>				8. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a. FACILITY NAME (If not institution, give street and number) <b>Select Specialty Hospital</b>				9b. CITY, TOWN, OR LOCATION OF DEATH <b>Hammond, IN 46320</b>			9c. COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Diana Schoolcraft</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Millwright</b>			12b. KIND OF BUSINESS/INDUSTRY <b>Steel Manufacturing</b>		
13a. RESIDENCE-STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Hammond</b>			13d. STREET AND NUMBER <b>3253 Kenwood Street</b>		
13a. ZIP CODE <b>46323</b>		13i. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. AS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE-American Indian, Black, White, etc. (Specify) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) <b>Allen Kirby</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Beatty</b>					

PARENTS

INFORMANT

20a. INFORMANT'S NAME (Type/Print) <b>Diana Kirby</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3253 Kenwood Street, Hammond, IN 46323</b>		20c. Relationship <b>Wife</b>	
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DISPOSITION

21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) <b>November 22, 2004 Elmwood Cemetery</b>		21c. LOCATION-City or Town, State <b>Hammond, IN</b>	
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CERTIFIER

22a. EMBALMER'S NAME <b>Jose A. Corona</b>		22b. EMBALMER'S LICENSE NO. <b>FD08601373</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Jody J. Zelle</i>		24b. LICENSE NUMBER (of Licensee) <b>FD20100056</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Virel Huber Funeral Home 7051 Kennedy Avenue Hammond, IN 46323 FH10300032</b>	

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) <b>Severe heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): 1. <b>End stage renal disease</b> DUE TO (OR AS A CONSEQUENCE OF): 2. <b>Myo-dystrophic Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): 3. <b>Sepsis</b>		Approximate Interval Between Onset and Death	
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HEALTH OFFICER

PART II, Other significant conditions - Conditions contributing to death but not previously stated in Part I.		27. WAS DECEDENT PREGNANT OR 80 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>	
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>[Signature]</i> M.D.		29c. MEDICAL LICENSE NO. <b>01055426 A</b>		29d. DATE SIGNED (Month, Day, Year) <b>11/22/04</b>	

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) <b>Dr. Majety, 5454 Holman Ave, Hammond, IN 46320</b>		31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> M.D.		32. DATE FILED (Month, Day, Year) <b>November 22, 2004</b>	
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33. MANNER OF DEATH <input checked="" 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-A 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.					

**EXHIBIT "A"**

**LOT 43 IN BLOCK 2 IN EASTGATE SUBDIVISION, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 30 PAGE 16, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.**

PARCEL ID NUMBER: 26-33-0223-0043

COMMONLY KNOWN AS: 3253 KENWOOD STREET  
HAMMOND, IN 46323

