3

2006 015223

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Barbara M. Corns, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, **Robert G. Corns**, died (without leaving a will) (leaving a will) on October 26, 2001 at Lowell, Lake County, INDIANA.
2. That they were duly and legally married at the time they acquired title as Husband and Wife in the following described real estate:

THE WEST SEVENTY SIX (76) FEET OF THE FOLLOWING DESCRIBED PROPERTY: A PART OF THE SOUTHWEST QUARTER (SW1/4) OF THE SOUTHWEST QUARTER (SW1/4) OF SECTION TWENTY THREE (23), TOWNSHIP 33 NORTH, RANGE 9 WEST OF THE SECOND PRINCIPAL MERIDIAN, COMMENCING AT A POINT 248 FEET WEST OF THE SOUTHEAST CORNER OF SAID FORTY ACRE TRACT, AND RUNNING THENCE NORTH ALONG THE WEST LINE OF LIBERTY STREET, 9 RODS; THENCE WEST 12 RODS; THENCE SOUTH 9 RODS; THENCE EAST 12 RODS TO THE PLACE OF BEGINNING, IN THE TOWN OF LOWELL, LAKE COUNTY, INDIANA, TOGETHER WITH THE IMPROVEMENTS THEREON SITUATED.

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 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 included 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.

COMMUNITY TITLE COMPANY
FILE NO L 33201

Barbara M Corns
Barbara M. Corns

Subscribed and sworn to before me, a Notary Public this 23 day of February, 2006.

Notary Public

My Commission Expires: 5/9/09
County of Residence: Lake

ELIZABETH R. KNZIE
NOTARY PUBLIC - INDIANA
COUNTY OF LAKE
MY COMMISSION EXPIRES
MAY 9, 2009

This instrument prepared by PATRICK J. McMANAMA, Attorney-at-Law, Attorney ID No. 15[illegible]45
No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

FILED
FEB 27 2006
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

$14
CM
CA

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. 2417-01 35467 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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Robert G. Corns	Male	05:05P M	October 26, 2001

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
307-14-6973	77			Jan 19, 1924	Frankfort, IN

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
Yes	1946	HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
220 W. Commercial Ave.	Lowell	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Barbara M. Uhl	Optometrist	Medical

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Lowell	220 W. Commercial Ave.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46356	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	4

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Walter Vernon Corns	Mabel McKown

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Barbara M. Corns	220 W. Commercial Ave. Lowell, IN 46356	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____ ☐ Entombment	October 31, 2001 Bunnell Cemetery	Frankfort, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Molly E. Tucker Hawkins	FD09200061	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Molly E. Hawkins	FD09200061	Sheets Funeral Home, FHS3004277 604 E. Commercial Ave. Lowell, IN

USE 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. Carcinoid Tumor
DUE TO (OR AS A CONSEQUENCE OF)
b. Liver Metastasis
DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last
c. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF)
d.

Approximate Interval: Onset to Death

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATION OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

DEC 08 2003

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)
N/A	No	N/A

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
Randall Hile	01030934	10/29/01

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Randall Hile MD, 1020 E. Commercial Ave., Lowell, IN 46356

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Susan W Bast D.O.	October 30, 2001

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

Prescribed by the
State Board of Accounts
(2005)

County Form 170

Declaration

This form is to be signed by the preparer/verifier of a document and recorded with each document in accordance with IC 36-2-7.5-5(a)

I, the undersigned verifier of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security numbers.

2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, the undersigned, affirm under the penalties of perjury, that the forgoing declarations are true.

Signature of Declarant

Elizabeth B. Kinzie

Printed Name of Declarant