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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.

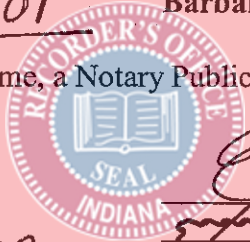
**FURTHER**, Affiant sayeth not.

COMMUNITY TITLE COMPANY  
FILE NO L 33201

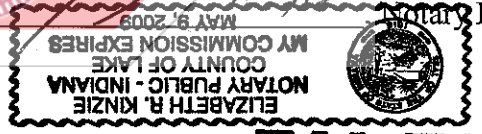
Barbara M Corns  
Barbara M. Corns

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

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



Elizabeth R. Kinzie  
Notary Public



This instrument prepared by PATRICK J. McMANAMA, Attorney-at-Law, Attorney II, No. 5145  
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

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORDING  
MICHAEL J. SHROVE  
2006 FEB 27 AM 11:05

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CA

009147

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 2417-01

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

35467  
PE/PRINT  
IN  
PERMANENT  
ACK INK

DECEDENT

MENTS

FORMANT

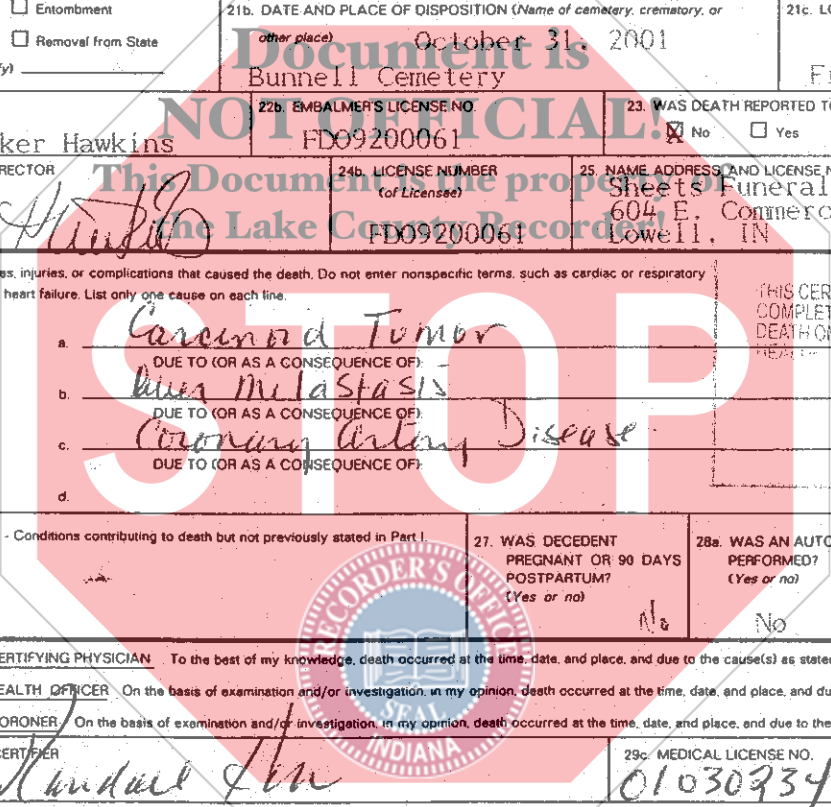
POSITION

USE OF  
ATH

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ALTH  
ICER

1. DECEASED—NAME (First, Middle, Last) Robert G. Corns			2. SEX Male		3a. TIME OF DEATH 05:05P <sub>M</sub>		3b. DATE OF DEATH (Month, Day, Yr) October 26, 2001					
4. *SOCIAL SECURITY NUMBER 307-14-6973		5a. AGE—Last Birthday (Years) 77		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) Jan 19, 1924		7. BIRTHPLACE (City and State or Foreign Country) Frankfort, IN		
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence								
9b. FACILITY NAME (If not institution, give street and number) 220 W. Commercial Ave.					9c. CITY, TOWN, OR LOCATION OF DEATH Lowell			9d. COUNTY OF DEATH Lake				
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Barbara M. Uhl			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Optometrist			12b. KIND OF BUSINESS/INDUSTRY Medical				
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Lowell			13d. STREET AND NUMBER 220 W. Commercial Ave.					
13e. ZIP CODE 46356		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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+) 4		
18. FATHER'S NAME (First, Middle, Last) Walter Vernon Corns						19. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel McKown						
20a. INFORMANT'S NAME (Type/Print) Barbara M. Corns				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 W. Commercial Ave., Lowell, IN 46356				20c. Relationship Wife				
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) October 31, 2001 Bunnell Cemetery			21c. LOCATION—City or Town, State Frankfort, IN						
22a. EMBALMER'S NAME Molly E. Tucker Hawkins				22b. EMBALMER'S LICENSE NO. FD09200061		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Molly E. Hawkins</i>				24b. LICENSE NUMBER (of Licensee) FD09200061		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home, FHS3004277 604 E. Commercial Ave., Lowell, IN						
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>Carcinoid Tumor</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>lung metastasis</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Coronary Artery Disease</u> DUE TO (OR AS A CONSEQUENCE OF): d. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last							APPROXIMATE TIME BETWEEN COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT OCT 28 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) 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) N/A			
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>Randall Hile</i>						29c. MEDICAL LICENSE NO. 01030934			29d. DATE SIGNED (Month, Day, Year) 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												
31. HEALTH OFFICER'S SIGNATURE <i>Susan W Best DO</i>								32. DATE FILED (Month, Day, Year) October 30, 2001				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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			
34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)						34d. 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.								




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

