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AFFIDAVIT

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDER

STATE OF INDIANA
COUNTY OF LAKE

) 2006 069223
) SS:

2006 AUG -9 AM 11: 21

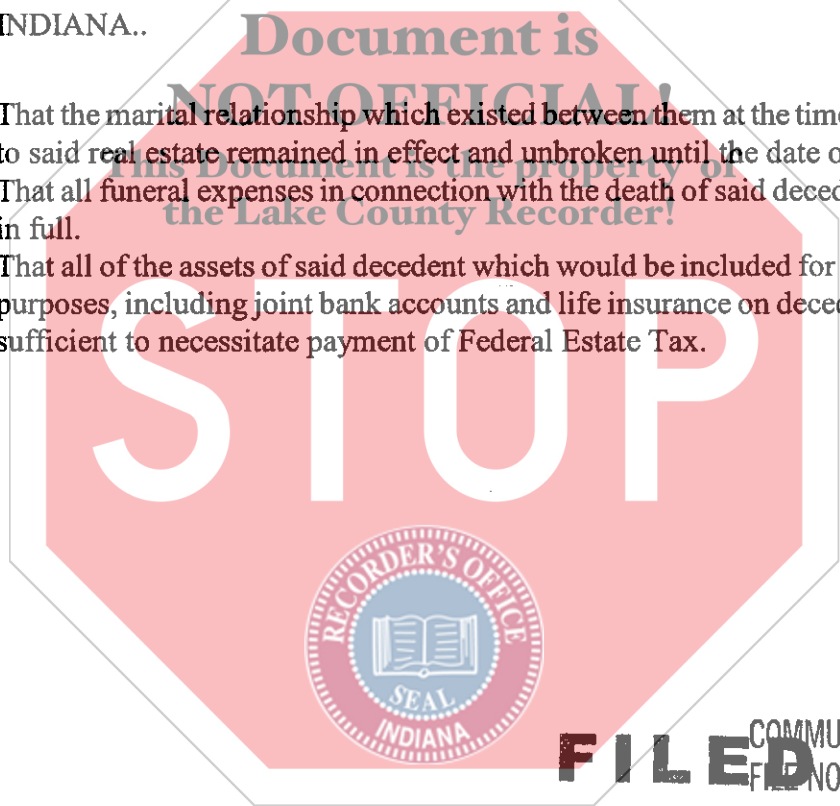
MICHAEL BROWN
RECORDER

CAROL F. SANDERS, being first duly sworn upon oath, deposes and says:

1. That Affiant's Husband, **RICHARD D. SANDERS**, died without leaving a will on April 14, 2006 at St. Mary Medical Center, Lake County, Indiana.
2. That the Affiant and **RICHARD D. SANDERS** were duly and legally married at the time they acquired title in the following described real estate:

THE WEST 56 FEET OF LOT 20 AND THE EAST 4 FEET OF LOT 21, BEL-AIR OF EAST GARY, BEING A RE-SUBDIVISION OF PART OF BLOCKS 1, 2, 3, AND ALL OF BLOCK 4, MALMSTENS EAST GARY SUBDIVISION, IN THE CITY OF LAKE STATION, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 43, PAGE 54, 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 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.



FILED COMMUNITY TITLE COMPANY
FILE NO L 34970

AUG - 9 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

014872

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CM
LD

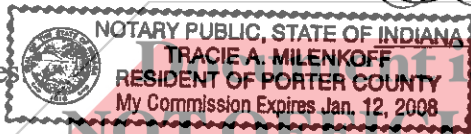
FURTHER, Affiant sayeth not.

Carol F. Sanders
Carol F. Sanders

Subscribed and sworn to before me, a Notary Public this 28th day of JULY, 2006.

Tracie A. Milenkoff
Tracie A. Milenkoff, Notary Public

My Commission Expires
County of Residence:

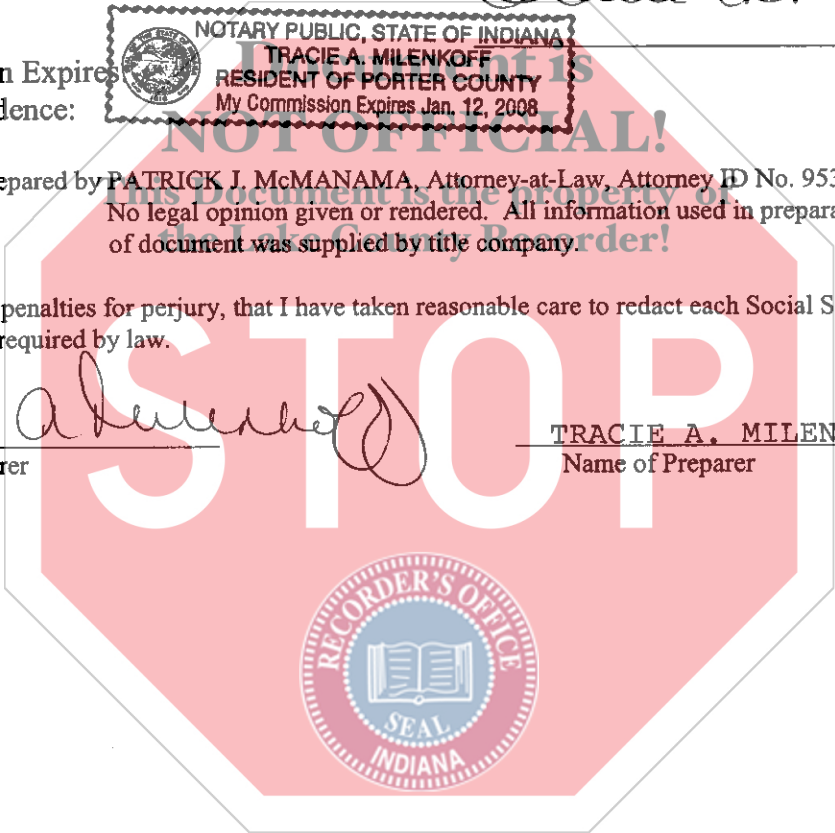


This instrument prepared by PATRICK J. McMANAMA, Attorney-at-Law, Attorney ID No. 9534-45.
No legal opinion given or rendered. All information used in preparation of document was supplied by title company.

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this Document, unless required by law.

Tracie A. Milenkoff
Signature of Preparer

TRACIE A. MILENKOFF
Name of Preparer



* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.

Local No. 967-06

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED - NAME (First, Middle, Last) Richard D. Sanders		2. SEX Male		3a. TIME OF DEATH 8:07 pm		3b. DATE OF DEATH (Month, Day, Yr.) April 14, 2006	
4. *SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE - Last Birthday (Years) 63		5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 DAY Hours: _____ Minutes: _____	
6. DATE OF BIRTH (Mo., Day, Yr.) June 03, 1942		7. BIRTHPLACE (City and State or Foreign Country) Gary Indiana					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? _____		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) St. Mary Medical Center				9c. CITY, TOWN, OR LOCATION OF DEATH Hobart		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Carol Reed		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Owner		12b. KIND OF BUSINESS/INDUSTRY Riches' Marina	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Lake Station		13d. STREET AND NUMBER 4840 E. 26th Avenue	
13e. ZIP CODE 46405		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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.)	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		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+) N/A			
18. FATHER'S NAME (First, Middle, Last) Richard L. Sanders				19. MOTHER'S NAME (First, Middle, Maiden Surname) Jeanne Margaret Van Buskirk			
20a. INFORMANT'S NAME (Type/Print) Carol Sanders				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4840 E. 26th Avenue, Lake Station, IN		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <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) April 19, 2006 NW Indiana Cremation Service		21c. LOCATION - City or Town, State Crown Point, Indiana			
22a. EMBALMER'S NAME Terrence P. Burns		22b. EMBALMER'S LICENSE NO. 01013890		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-			
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 in each line. Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Coronary Heart Disease with acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): c. Infected wounds, left leg DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Diabetic Nephropathy, Retinopathy, Neuropathy							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) 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) _____			
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>Rodolfo Jao</i>				29c. MEDICAL LICENSE NO. 01026118		29d. DATE SIGNED (Month, Day, Year) 4-19-06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26)(Type/Print) Rodolfo Jao M.D. 1400 S. Lake Park, Med. Arts. Bldg., Hobart, IN							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>						32. DATE FILED (Month, Day, Year) April 20, 2006	
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"/> Homicide <input type="checkbox"/> Could not be Determined		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) MAY 11 2006			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) April 14, 2006		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.					