

3

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 073778

2006 AUG 23 AM 11:14

AFFIDAVIT OF HEIRSHIP
MICHAEL A. BROWN
RECORDER

STATE OF INDIANA)
)
COUNTY OF LAKE)

Michael A. DeYoung, being duly sworn upon his oath and subject to the penalties for perjury, states that he resides at 1441 177th Court, Lowell, Lake County, Indiana.

That he was acquainted with Eleanor L. Foy, deceased, who, at the time of her death, was a co-owner of land situated in the City of Dyer, County of Lake, State of Indiana, legally described as:

Lot 35, Unit 3 Pheasant Hills Addition to Dyer, Indiana and commonly known as 633 Laurel Drive, Dyer, Indiana, as recorded in Recorder's Office of Lake County, Indiana.

This real estate is more commonly known as 633 Laurel Drive, Dyer, Lake County, Indiana 46311-2231.

This Document is the property of

This real estate has been assigned tax key number 12-14-0127-0035

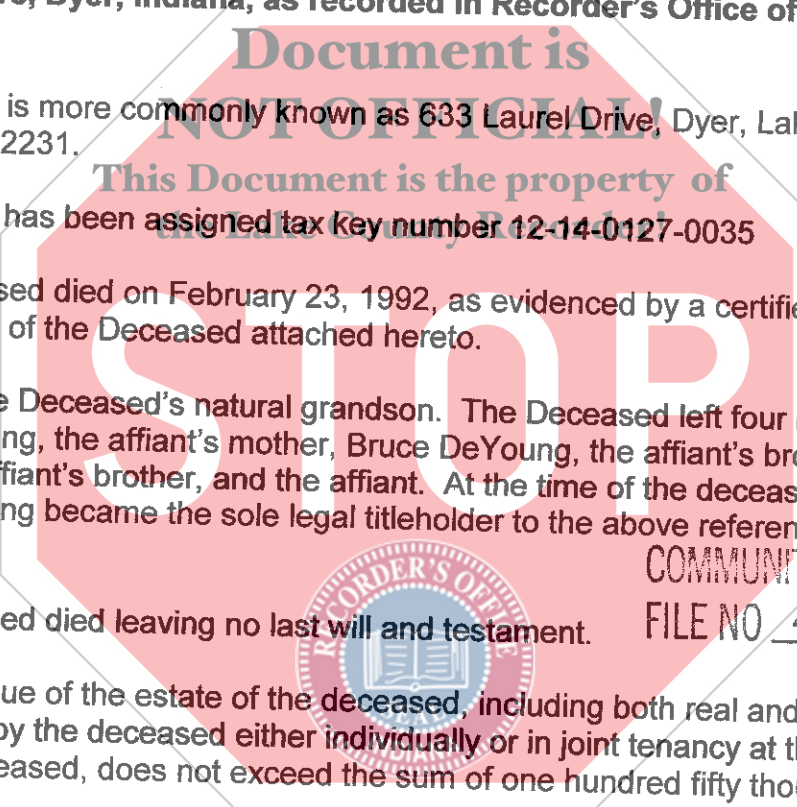
That the Deceased died on February 23, 1992, as evidenced by a certified copy of the death certificate of the Deceased attached hereto.

The affiant is the Deceased's natural grandson. The Deceased left four heirs, namely Judith A. DeYoung, the affiant's mother, Bruce DeYoung, the affiant's brother, DeYoung, the affiant's brother, and the affiant. At the time of the deceased's death, Judith A. DeYoung became the sole legal titleholder to the above referenced real estate.

That the Deceased died leaving no last will and testament.

That the total value of the estate of the deceased, including both real and personal property owned by the deceased either individually or in joint tenancy at the time of the death of the deceased, does not exceed the sum of one hundred fifty thousand dollars (\$150,000.00).

The Deceased was not married at the time of her death. That all of the Deceased's heirs now living have consented to the sale of the real estate enumerated above and have approved of and signed a warranty deed transferring the legal title to said real estate to Terry Groot, Faythe Groot, Henry Groot, and Tricia Groot, tenants in common.



FILED
AUG 23 2006

REGINA HOLINGA KATONA
LAKE COUNTY AUDITOR

COMMUNITY TITLE COMPANY

FILE NO 34422

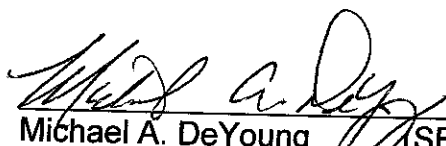
1500
LM
B

16514

That the heirs of the Deceased have all signed an indemnification agreement to hold McColly Community Title and Stewart Title Guaranty harmless from any claims made by any parties against the Estate of the Deceased.

I hereby swear or affirm under the penalties for perjury that the foregoing statements are true and accurate to the best of my knowledge, information, and belief.

DATED: June 1, 2006

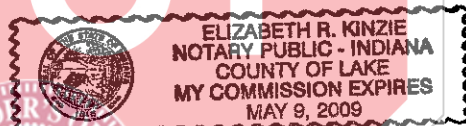

Michael A. DeYoung (SEAL)

I, the undersigned, a Notary Public in and for Lake County, State of Indiana, do HEREBY CERTIFY that Michael A. DeYoung personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that he signed, sealed and delivered said instrument as her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 1st day of June, 2006.

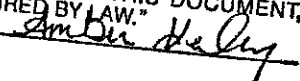
My commission expires on 5/9, 2009.


Notary Public, State of Indiana



I am a resident of Lake County, Indiana.



"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."
PREPARED BY: 

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0439-92

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

DRONER

SE ONLY

1. DECEASED—NAME (First, Middle, Last) Elynor L. Foy				2. SEX Female	3a. TIME OF DEATH 7:35P.M.	3b. DATE OF DEATH (Month, Day, Yr.) February 23, 1992
4. SOCIAL SECURITY NUMBER 336-03-9249	5a. AGE—Last Birthday (Years) 73	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) May 1, 1918	7. BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois	
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? No	9a. 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				
9b. FACILITY NAME (If not institution, give street and number) St. Anthony's Hospital			9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) None	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Auditor			12b. KIND OF BUSINESS/INDUSTRY Walgreen Drug Co.	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Dyer		13d. STREET AND NUMBER 633 Laurel Dr.		
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+) 0	
18. FATHER'S NAME (First, Middle, Last) George J. Revoir				19. MOTHER'S NAME (First, Middle, Maiden Surname) Anna AschBrenner		
20a. INFORMANT'S NAME (Type/Print) Judy DeYoung			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 Laurel Dr. Dyer, Indiana 46311		20c. Relationship Daughter	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) February 27, 1992 St. Mary's Cemetery			21c. LOCATION—City or Town, State Evergreen Park, Ill.	
22a. EMBALMER'S NAME Lawrence Miller			22b. EMBALMER'S LICENSE NO. FDE1006015	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR (Type/Print) <i>Lawrence Miller</i>		24b. LICENSE NUMBER (of Licensee) FDE1006015	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens for Rosemoor Funeral Home 1920 Hart St. Dyer, Ind. FH830015C			
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. FEB 25 1992 Chronic Obstructive Airway Disease Respiratory failure 2 to A Cor Pulmonale DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death						
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) 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>Paul Schaffert DO</i>				29c. MEDICAL LICENSE NO. 2000709	29d. DATE SIGNED (Month, Day, Year) 2/25/92	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) PAUL SCHAFFERT DO 297 Franciscan STE 108, Grumbards						
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>					32. DATE FILED (Month, Day, Year) February 25, 1992	
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	
		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.			