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TICOR TITLE INSURANCE

2006 082427

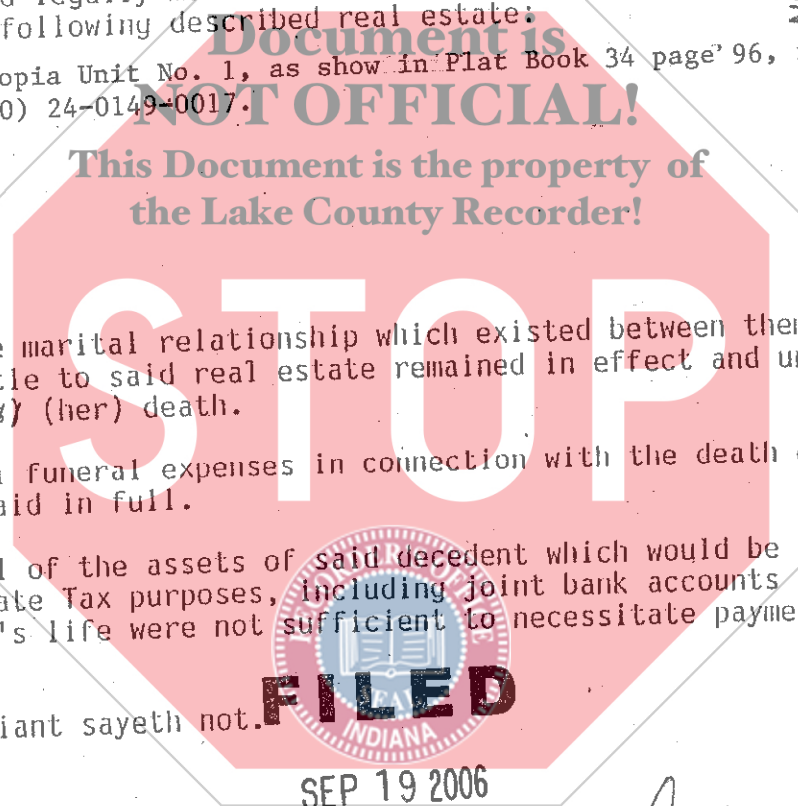
AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Donald W. Tussey, being first duly sworn upon oath, deposes and says:

1. That Charlotte Tussey, 19 at Crown Point, Indiana, died on April 27, 2006.
2. That Donald W. Tussey and Charlotte Tussey were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
Lot 17 in Utopia Unit No. 1, as show in Plat Book 34 page' 96, in Lake County, Indiana. (30) 24-0149-0017.

STATE OF INDIANA
LAKE COUNTY
FILED FOR REC'D
2006 SEP 20 AM 8:57
MICHAEL E. BROWN
REC'D



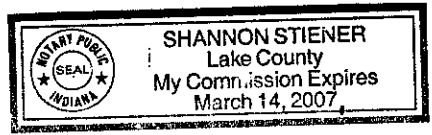
3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of ~~(his)~~ (her) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets of said decedent which would be includable 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.

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Donald W. Tussey
Donald W. Tussey

Subscribed and sworn to before me, a Notary Public, this 15th day of September, 19 2006.



Shannon Stiener
Shannon Stiener - Notary Public

My Commission expires:
3-14-07

County of Residence:
Lake

This Instrument prepared by Donald W. Tussey

"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." Chris Burk

BURNET TITLE

\$14
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CP

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to insure 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. 1049-06

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) Charlotte A Tussey				2. SEX Female		3a. TIME OF DEATH 8:10P M		3b. DATE OF DEATH (Month, Day, Yr.) April 27, 2006	
4. *SOCIAL SECURITY NUMBER 306-36-7820		5a. AGE—Last Birthday (Years) 69		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) October 11 1936	
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, IN		8a. WAS DECEDENT A U.S. VETERAN? No							
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NA		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 Medical Center				9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point			9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Donald Tussey		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker			12b. KIND OF BUSINESS/INDUSTRY Family Residence		
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Cedar Lake			13d. STREET AND NUMBER 13620 Parrish Avenue		
13e. ZIP CODE 46303		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+) 				18. FATHER'S NAME (First, Middle, Last) Wayne Baden				19. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown	
20a. INFORMANT'S NAME (Type/Print) Donald Tussey				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13620 Parrish Ave Cedar Lake, IN 46303				20c. Relationship Spouse	
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) May 3, 2006 German Methodist Cemetery				21c. LOCATION—City or Town, State Cedar Lake, IN	
22a. EMBALMER'S NAME Dean Wagner				22b. EMBALMER'S LICENSE NO. FD8800057		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>William E. Burdick</i>				24b. LICENSE NUMBER (of Licensee) FD01007697		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burdan Funeral Home FH83002461 12901 Wicker Ave Cedar Lake IN 46303			
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. THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE STATEMENT OF THE CAUSE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. DUE TO (OR AS A CONSEQUENCE OF): a. cardiac arrest b. Dilated Pheumatic cardiomyopathy c. MAY 01 2006 d. Peripheral Vascular Disease PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.								46303 Approximate Interval Between Onset and Death	
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM (Yes or no) NO				28a. WAS AN AUTOPSY PERFORMED? 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>V.R. Bandura</i>		29c. MEDICAL LICENSE NO. 91029999		29d. DATE SIGNED (Month, Day, Year) 5-1-06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 1205 S. MAIN ST. #101 CROWN POINT, IN. 46307-DR. V. G. MALO									
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Butler D.O.</i>							32. DATE FILED (Month, Day, Year) May 1, 2006		
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) 018608							
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					