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**AFFIDAVIT**

STATE OF Indiana )  
COUNTY OF Lake ) SS:

**Jane E. Davis**, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, **Gary A. Davis, Sr.**, died (without leaving a will) (leaving a will) on November 20, 2006 Methodist Hospital – South Lake Campus, Merrillville, 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 EAST 79.2 FEET IN WIDTH OFF THAT PART OF THE NORTHWEST QUARTER OF SECTION 8, TOWNSHIP 34 NORTH, RANGE 8 WEST OF THE 2<sup>ND</sup> PRINCIPAL MERIDIAN, IN THE CITY OF CROWN POINT, LAKE COUNTY, INDIANA, DESCRIBED AS FOLLOWS:**

**SEE LEGAL DESCRIPTION CONTINUED ON REVERSE SIDE HEREOF**

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.

**FURTHER, Affiant sayeth not.**

COMMUNITY TITLE COMPANY  
FILE NO L 37313

Jane E. Davis  
Jane E. Davis

Subscribed and sworn to before me, a Notary Public this 18th day of May, 2007.

My Commission Expires: \_\_\_\_\_  
County of Residence: \_\_\_\_\_

Karen Craig, Notary Public  
(PRINTED NAME)

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.



**FILED**

MAY 31 2007

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

**\*I AFFIRM, UNDER THE PENALTIES FOR PERJURY, THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, WHERE APPLICABLE BY LAW.**

007165

#16  
CM  
CA

DAVIS / SAQUI

FROM A POINT ON THE SOUTH LINE OF JOLIET STREET, IN THE CITY OF CROWN POINT, WHICH IS 656 FEET DUE EAST OF THE WEST LINE OF SAID QUARTER SECTION (WHICH POINT IS ALSO THE NORTHWEST CORNER OF LOT 1, IN GLEN ROYAL SUBDIVISION), RUN SOUTH PARALLEL WITH THE WEST LINE OF SAID QUARTER SECTION, 869.4 FEET TO THE PLACE OF BEGINNING OF THIS DESCRIPTION; THENCE WEST 9.2 FEET TO A POINT; THENCE SOUTH PARALLEL WITH THE WEST LINE OF SAID QUARTER SECTION, 240.9 FEET TO A POINT, WHICH IS 13.35 CHAINS NORTH OF THE EAST AND WEST CENTER LINES OF SAID SECTION 8; THENCE EAST PARALLEL WITH SAID EAST AND WEST CENTER SECTION LINE 279.2 FEET TO A POINT; THENCE NORTH PARALLEL WITH THE WEST LINE OF SAID QUARTER SECTION 240.9 FEET TO A POINT; THENCE WEST 270 FEET TO THE PLACE OF BEGINNING.



ATTENTION ESTATE: Disclosure of the facts 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. 2830-06

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) <b>Gary A. Davis, Sr.</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>9:32 pm</b>	3b. DATE OF DEATH (Month, Day, Year) <b>November 20, 2006</b>
4. SOCIAL SECURITY NUMBER <b>266-90-7515</b>		5a. AGE - Last Birthday (Years) <b>55</b>	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____
6a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1970</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Ft. Lauderdale Florida</b>
8a. FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital - South Lake Campus</b>		8b. CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>		8c. COUNTY OF DEATH <b>Lake</b>
9. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Jane Clinton</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Truckdriver</b>
10. RESIDENCE - STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN OR LOCATION <b>Crown Point</b>
13d. ZIP CODE <b>46307</b>		13e. STREET AND NUMBER <b>424 W. Walnut Sreet</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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) <b>White</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5-) <b>N/A</b>
18. FATHER'S NAME (First, Middle, Last) <b>Charles Davis</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ernestine Bobo</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Jane Davis</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>424 W. Walnut Sreet, Crown Point, IN</b>		20c. Relationship <b>WIFE</b>
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) <b>November 25, 2006 N. W. Indiana Cremation Services</b>		21c. LOCATION - City or Town, State <b>Crown Point IN</b>
22a. EMBALMER'S NAME <b>James F. Burns</b>		22b. EMBALMER'S LICENSE NO. <b>1009461</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01009461</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana</b>
26. PART I: Enter the disease, 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. <b>cardio respiratory arrest surgery for ruptured spleen trauma</b>				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>				
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>				
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>				
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) as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James F. Burns</i>		29c. MEDICAL LICENSE NO. <b>01033726A</b>		29d. DATE SIGNED (Month, Day, Year) <b>11-28-06</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20f) (Type/Print) <b>Dr. A. Atasi 206 E. 86th Place, Merrillville, IN</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>				
32. MANNER OF DEATH <input 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				
33a. DATE OF INJURY (Month, Day, Year) <b>NOV 29 2006</b>		33b. TIME OF INJURY		33c. INJURY AT WORK? (Yes or no)
34a. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34b. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
34c. DATE PRONOUNCED DEAD (Month, Day, Year) <b>November 20, 2006</b>		34d. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.		



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE ORIGINAL DEATH CERTIFICATE FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT ON **NOV 29 2006**