

2.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE)

2007 096554

2007 DEC 10 AM 11:12

) SS:

MICHAEL A. BROWN
RECORDER

27-18-0221-0515, 0516

DOUGLAS JASPER ALLISON, being first duly sworn upon oath, depose and say:

1. That **EVA FLORINE ALLISON a/k/a EVA F. ALLISON**, died without leaving a will on February 2, 2006 at VNA Horton VNA Hospice Center, Porter County, Indiana.
2. That **DOUGLAS JASPER ALLISON** acquired title with **EVA FLORINE ALLISON**, who survived him in death, as Tenants In Common, in the following described real estate:

LOTS FIFTEEN (15) AND SIXTEEN (16) IN MCAFEE'S CLEVELAND AVENUE ADDITION TO HOBART, INDIANA, RECORDED IN PLAT BOOK 25 PAGE 20 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

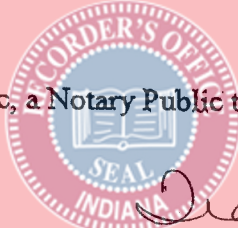
3. That the following person (s) are the true and lawful heir(s) of EVA FLORINE ALLISON a/k/a EVA F. ALLISON: Douglas Jasper Allison (son).
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets of said decedent which would be included 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, Affiants saith naught.

"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: Ambu Healy

Douglas Jasper Allison
Douglas Jasper Allison

Subscribed and sworn to before me, a Notary Public this 29th day of NOVEMBER, 2007.



Tracie A. Milenkoff
Tracie A. MILENKOFF, Notary Public

My Commission Expires: 01/12/08
County of Residence: PORTER

14
CSC

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.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

024197

DEC - 6 2007

COMMUNITY TITLE COMPANY
FILE NO L38774

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

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) Eva F. Allison		2. SEX Female	3a. TIME OF DEATH 7:39 am	3b. DATE OF DEATH (Month, Day, Yr.) February 2, 2006
4. *SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE - Last Birthday (Years) 86	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) October 24, 1919
7a. WAS DECEDENT A U.S. VETERAN? No	7b. YEAR LAST SERVED IN U.S. ARMED FORCES? -	7. BIRTHPLACE (City and State or Foreign Country) Gary Indiana		
8. 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 checked="" type="checkbox"/> Other (Specify) Hospice				
9b. FACILITY NAME (If not institution, give street and number) VNA Horton Hospice Center		9c. CITY, TOWN, OR LOCATION OF DEATH Valparaiso	9d. COUNTY OF DEATH Porter	
10. MARITAL STATUS (Specify) Widowed	11. SURVIVING SPOUSE (If wife, give maiden name) N/A	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 At Home
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 2114 E. Cleveland Avenue	
13e. ZIP CODE 46342	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.)	16. RACE - American Indian, Black, White, etc. (Specify) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A		18. FATHER'S NAME (First, Middle, Last) Jasper Stephenson		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Amanda Williamson		20a. INFORMANT'S NAME (Type/Print) Douglas Allison		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 Midway Drive, Valparaiso, IN 46385		20c. Relationship Son		
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) February 6, 2006 Calumet Park Cemetery		21c. LOCATION - City or Town, State Merrillville, Indiana
22a. EMBALMER'S NAME James F. Burns		22b. EMBALMER'S LICENSE NO. 01009461	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. 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 on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>multifocal degenerative neuropathy</i> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____				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? (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>[Signature]</i>		
		29c. MEDICAL LICENSE NO. 01048722	29d. DATE SIGNED (Month, Day, Year) 2/3/06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) Robert Chen M.D. 2000 Roosevelt Road, Suite 5, Valparaiso, IN 46383				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> February 3, 2006				
32. DATE FILED (Month, Day, Year)		33. MANNER OF DEATH <input checked="" 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) February 2, 2006		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.		