

DECEASED JOINT TENANT AFFIDAVIT

3pg
State of Indiana)
County of Lake) SS

Date: 12-4-07
File: 07000878

Eugene Thomas Webb Jr, being first duly sworn, for the purpose of inducing Residential Title Services, Inc. to issue its title insurance policy covering the land described in the above captioned commitment, deposes and says;

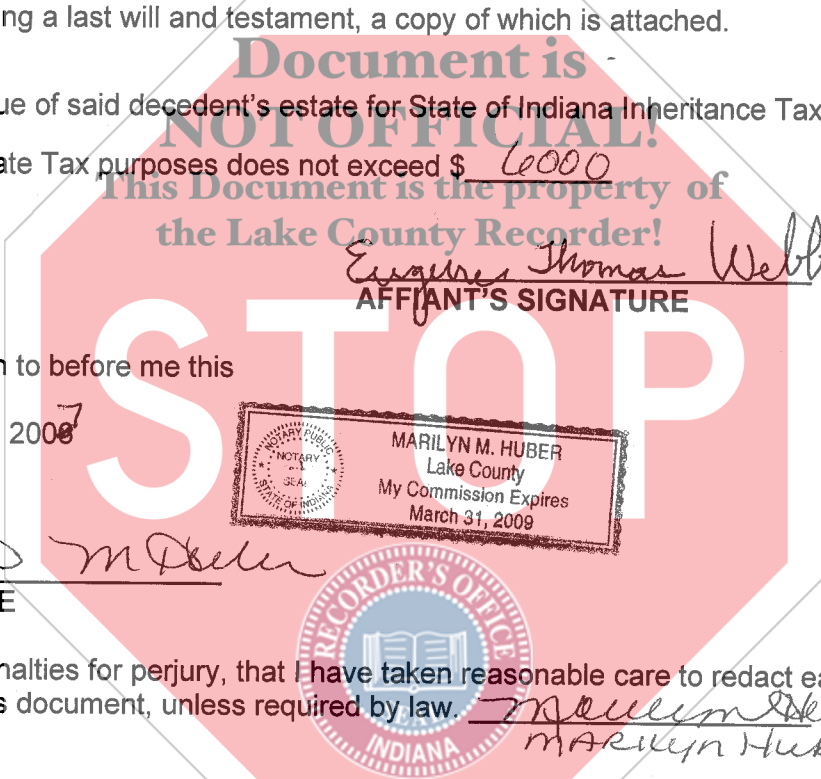
1. That he/she resides at: 6319 Nevada Ave, Hammond, IN 46323
2. That he/she was acquainted with Judith B. Webb who died on 11-19-88 as evidence by the attached certified copy of the death certificate.
3. That said decedent was one of the owners of the land described in the above captioned commitment.
4. That said decedent died:
 leaving no will and last testament.
 leaving a last will and testament, a copy of which is attached.
5. That the total value of said decedent's estate for State of Indiana Inheritance Tax/Estate Tax and Federal Estate Tax purposes does not exceed \$ 6000

2007 099274

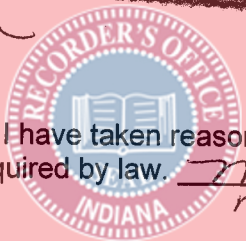
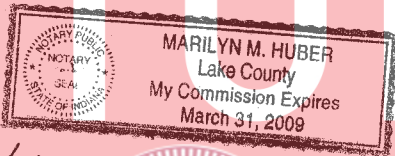
2007 DEC 19 PM 12:21

MICHAEL A. BROWN
RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD



Eugene Thomas Webb Jr
AFFIANT'S SIGNATURE



Subscribed and sworn to before me this
4 day of Dec, 2007

Marilyn M. Huber
NOTARY SIGNATURE

"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."
Marilyn Huber

After Recording Return to:
This Document was Prepared By:
Marilyn Huber
233E. 84th Dr
Merrillville, IN 46440

Eugene Thomas Webb Jr.
6319 Nevada Ave
Hammond, IN 46323

\$ 16.-
✓ 6796

Sec.

INDIANA STATE BOARD OF HEALTH CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
NOV 2 2 1988
Franklin D. Remuda M.D.
Date Issued Hammond Health Commissioner

Local No. 950

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME FIRST: Judith MIDDLE: E. LAST: Webb			2. SEX Female	3. DATE OF DEATH (Mo., Day, Year) November 19, 1988
4. SOCIAL SECURITY NUMBER 306-56-9942	5a. AGE—Last Birthday (Years) 37	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Month, Day, Year) September 13, 1951
7. BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana	8. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A			
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"/> Residence <input type="checkbox"/> Other (Specify)				
9b. FACILITY NAME (If not institution, give street and number) St. Margaret Hospital		9c. CITY, TOWN, OR LOCATION OF DEATH Hammond		9d. COUNTY OF DEATH Lake
10. MARITAL STATUS—Married Never Married, Widowed, Divorced (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Eugene Webb	12a. DECEASED'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 Hammond		13d. STREET AND NUMBER 6319 Nevada
13e. INSIDE CITY LIMITS? (Yes or no) Yes	13f. FARM No	13g. ZIP CODE 46323	14. WAS DECEASED OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:	
15. RACE—American Indian, Black, White, etc. (Specify) White		16. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 1		
17. FATHER'S NAME (First, Middle, Last) Herman Stone			18. MOTHER'S NAME (First, Middle, Maiden Surname) Seigle Coppage	
19a. INFORMANT'S NAME (Type/Print) Eugene Webb		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6219 Nevada Hammond, Indiana 46323		19c. Relationship Husband
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) November 23, 1988 Northwest Indiana Cremation Service		20c. LOCATION—City or Town, State Crown Point, Indiana
21a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		21b. LICENSE NUMBER (of Licensee) FDE1018769	22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME C.J. Huber Funeral Home 722 165th Street Hammond, Indiana 46324 FDH3002851	
23a. Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death		23b. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title <		23c. LICENSE NUMBER
23d. DATE SIGNED (Month, Day, Year)		24. TIME OF DEATH 9:25 a.		
25. DATE PRONOUNCED DEAD (Month, Day, Year) November 19, 1988		26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No		
27. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. massive lower gastrointestinal hemorrhage DUE TO (OR AS A CONSEQUENCE OF) b. metastatic adenocarcinoma of the colon DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypoproteinemia; deep venous thrombosis				
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. <input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> CORONER <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) and manner as stated.		29b. LICENSE NUMBER 36259		29c. DATE SIGNED (Month, Day, Year) November 21, 1988
30. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) J. Gleaton, M.D. 7905 Calumet Avenue, Munster, Indiana 46321		
31. HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>			32. DATE FILED (Month, Day, Year) NOV 2 2 1988	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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)				

DECEDENT

PARENTS

INFORMANT

DISPOSITION

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

SEE INSTRUCTIONS

CAUSE OF DEATH

SEE INSTRUCTIONS

CERTIFIER

HEALTH OFFICER

CORONER OR MEDICAL EXAMINER USE ONLY

EXHIBIT "A"

ALL OF LOT 39, (EXCEPT THE SOUTH 8 1/2 FEET THEREOF), ALL OF LOT 40, AND ALL LOT 41, (EXCEPT THE NORTH 16 1/2 FEET THEREOF), IN BLOCK 2, I,F. PRITCHARD'S FIRST ADDITION TO THE CITY OF HAMMOND, AS SHOWN IN PLAT BOOK 10, PAGE 28B, IN LAKE COUNTY, INDIANA

PARCEL ID NUMBER: 26-35-0244-0040

COMMONLY KNOWN AS: 6319 NEVADA AVENUE
HAMMOND, IN 46323

