2008 079582

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2008 NOV 21 AM 9:24
MICHAEL A. BROWN
RECORDER

Beverly J. Ewing, being first duly

Sworn upon oath, deposes and says:

1. That Robert Lee Ewing
died on August 19, 2007 at 8:27AM

2. That Beverly J. Ewing and Robert Lee Ewing
were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 15 in Spring Dale Addition, in the City of Hobart, as per plat thereof, recorded in Plat Book 33, page 11, in the Office of the Recorder of Lake County, Indiana.
45-09-32-452-012.000-018

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STOP

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.

FILED
NOV 19 2008
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Beverly J. Ewing

Subscribed and sworn to before me, a Notary Public, this 23rd day of October, 2008.

STACI MARIE FINCH
Lake County
My Commission Expires
Feb. 20, 2016

Notary Public: staci Marie Finch

My commission expires: 2/20/16

County of Residence: Lake

"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

This Instrument prepared by: Beverly J. Ewing

928-5389
TICOR HDT

018510

14 TT
PB

Sep 23 08 01:58p Bob Allen 2199429348 p.1

10 + 2 Vet

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 2034-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): ROBERT LEE EWING
2. SEX: Male
3a. TIME OF DEATH: 8:27 AM
3b. DATE OF DEATH (Month, Day, Yr): August 19, 2007
4. *SOCIAL SECURITY NUMBER: [redacted]
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): January 27, 1934
7. BIRTHPLACE (City and State or Foreign Country): Gary Indiana
8a. WAS DECEDENT A U.S. VETERAN? YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1957
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 1013 E. 8th Street
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Beverly Emory
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Pipe Fitter
12b. KIND OF BUSINESS/INDUSTRY: Local #597
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 1013 E. 8th Street
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Lee A. Ewing, Sr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Ihnat

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Beverly Ewing
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1013 E. 8th Street, Hobart, IN 46342
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Aug 23, 2007 Kelly-Carroll Crematory
21c. LOCATION—City or Town, State: Gary IN
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO: FD01006463
23. WAS DEATH REPORTED TO CORONER? ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

CAUSE OF DEATH

28. 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. | Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): Esophageal Cancer

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

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

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated
☐ 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
☐ 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: [signature]
29c. MEDICAL LICENSE NO.: 01035453
29d. DATE SIGNED (Month, Day, Year): 8/22/07
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): John E. Carter MD 164 Bracken Pkwy, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan ... Bart DO
32. DATE FILED (Month, Day, Year): August 22, 20..

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

SDH06-004 State Form 10110 (R5/1-99)

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