2

TICOR TITLE INSURANCE

2009 081561

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2009 DEC -9 AM 9:18
MICHAEL A. BROWN
RECORDER

KEVIN Z BARNES, being first duly sworn upon oath, deposes and says:

1. That ETHEL A BARNES died on 11-16, 1999 at Merrillville, Indiana.

2. That ETHEL A BARNES and WILLIAM N BARNES were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 6 except the West 6 feet and the West 4 feet of Lot 7 in Parrish Avenue Fifth Addition to Hammond, as per plat thereof, recorded in Plat Book 30 page 43 in the Office of the Recorder of Lake County, Indiana.

45-07-16-232-006.000-023

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 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.

Kevin Z. Barnes

Subscribed and sworn to before me, a Notary Public, this 18 day of November, 19 2009.

RHONDA HOLLAWAY
Notary Public,
State of Texas
Comm. Exp. 09-23-11

Notary Public

My Commission expires:
9-23-11

County of Residence:
Tarrant

This Instrument prepared by KEVIN Z BARNES

FILED
DEC 07 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
DEC 07 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

$14
TI
CW

021406

REGION TITLE

TICOR HO

90 9105RT

SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 0137-99

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-15-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED-NAME (First Middle Last): ETHEL A. BARNES
2. SEX: Female
3a. TIME OF DEATH: 6:52PM
3b. DATE OF DEATH (Month Day Yr): January 16, 1999
4. SOCIAL SECURITY NUMBER: [redacted]-6536
5a. AGE - Last Birthday (Years): 75
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): Sep 30, 1923
7. BIRTHPLACE (City and State or Foreign Country): ATWOOD, IL
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES: N/A
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): METHODIST HOSPITAL SOUTHLAKE
9c. CITY TOWN OR LOCATION OF DEATH: MERRILLVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): WILLIAM H. BARNES
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: OWN HOME
13a. RESIDENCE - STATE: IN
13b. COUNTY: LAKE
13c. CITY TOWN OR LOCATION: HAMMOND
13d. STREET AND NUMBER: 3138-174TH COURT
13e. ZIP CODE: 46323
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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): LYLE BAKER
19. MOTHER'S NAME (First, Middle, Maiden Surname): EVA CORWIN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): WILLIAM H. BARNES
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3138-174TH COURT, HAMMOND, IN 46323
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jan 20, 1999 MACKVILLE CEMETERY
21c. LOCATION - City or Town State: ATWOO,, IL
22a. EMBALMER'S NAME: C. WILLIAM MCCOY
22b. EMBALMER'S LICENSE NO.: FDO1013612
22c. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
23a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
23b. LICENSE NUMBER (of Licensee): FDO1042047
23c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, Hammond, IN 46323

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries or complications that caused the death. Do not enter terminal events 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. Septic shock
DUE TO (OR AS A CONSEQUENCE OF):
Conditions if any which gave rise to the immediate cause stating the underlying cause last: b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death: hours

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: Alzheimers
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.
☐ MEDICAL 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: IN01040141
29d. DATE SIGNED (Month Day Year): 1/18/99
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): R.G. DEVANATHAN,M.D., 1600 S.LAKE PARK AVE.#1104, HOBART, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] MD
32. DATE FILED (Month Day Year): 1/19/99

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 Ooccurred:
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 10110-04 (R4 / 3-93) DEATHCERPD