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TICOR TITLE INSURANCE

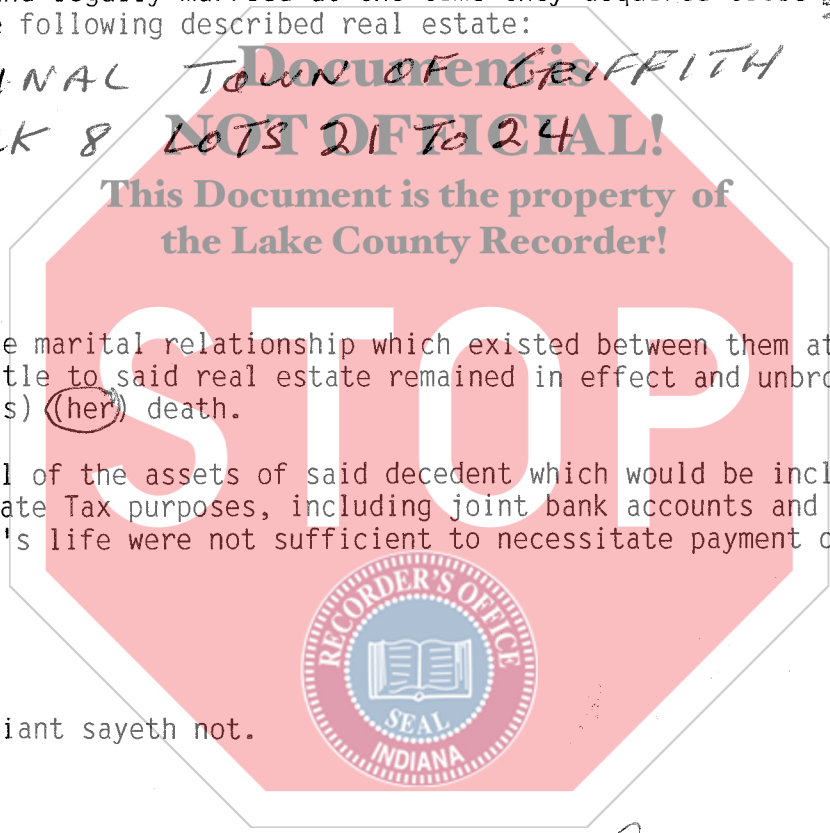
AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

ARNOLD L. STASSIN, being first duly
sworn upon oath, deposes and says:

1. That DONNA J. STASSIN
DECEMBER 24TH, 192008 at HOME 3:20 P.M.
2. That ARNOLD L. STASSIN and DONNA J. STASSIN
were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

ORIGINAL TOWN OF GRIFFITH
BLOCK 8 LOTS 21 TO 24!



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.

Arnold L. Stassin

Subscribed and sworn to before me, a Notary Public, this 22 day of March, 18 2010.

"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: _____

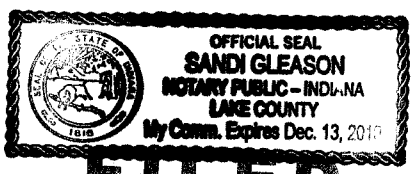
Sandi Gleason
Notary Public

My Commission expires:
12/13/10

County of Residence:
Lake

This Instrument prepared by _____

051603



FILED

MAR 22 2010

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

14
CS
RN

**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**



Local No. 4324-08

State No.

1. Decedent's Legal Name (First, Middle, Last) DONNA J. STASSIN				1a. Maiden Last Name (If Female) FOX		2. Sex F	3. Time Of Death 3:20PM	4. Date Of Death (Month/Day/Year) DECEMBER 24, 2008	
5. Social Security Number 304-32-9653	6a. Age Yrs 77	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year) September 13, 1931		8. Birthplace (City And State Or Foreign Country) PONEMAH, ILLINOIS	
9. Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead On Arrival			10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)				
11. Facility Name (If Not Institution, Give Street And Number) 302 N. ELMER									
12. City Or Town, State, And Zip Code GRIFFITH, INDIANA 46319					13. County Of Death LAKE		14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name ARNOLD STASSIN				15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation HOMEMAKER		17. Kind Of Business/Industry OWN HOME	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town GRIFFITH					
18c. Street And Number 302 N. ELMER					18d. Apt. No.	18e. Zip Code 46319		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education High school graduate or GED completed		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino			21. Decedent's Race White				
22. Father's Name (First, Middle, Last) SYLVESTER E. FOX				23. Mother's Name (First, Middle, Last) CARRIE E. FOX			23a. Mother's Maiden Last Name TUBBS		
24. Informant's Name ARNOLD STASSIN		24a. Relationship To Decedent HUSBAND		24b. Mailing Address (Street And Number, City, State, Zip Code) 302 N. ELMER GRIFFITH, INDIANA 46319					
25. Place Of Disposition									
25a. Method Of Disposition: <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):		25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) KELLY CARROLL CREMATORY			25c. Location - City, Town, And State GARY, INDIANA				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility WHITE FUNERAL HOME & CREMATION SERVICE 921 W. 45TH AVENUE, GRIFFITH, IN 46319					27a. Funeral Home License Number: FH10600026		
27b. Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>						27c. License Number (Of Licensee) FD08700086			
28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary. Immediate Cause (Final Disease Or Condition Resulting In Death) A. <u>Metastatic Endometrial Cancer</u> B. _____ C. _____ D. _____ Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last									
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval: Onset To Death JAN 08 2009	
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year			33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)			37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No.	38d. Zip Code		
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
41. Signature Of Person Certifying Cause Of Death: <i>Barbara L. Fuller, M.D.</i>						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: <i>Barbara L. Fuller, M.D., 801 MacArthur Blvd Ste 401, Munster, IN 46321</i>						44. License Number <i>01034701</i>		45. Date Certified <i>12/30/2008</i>	
46. Additional Funeral Service Provider:						47. *Akas:			
48. Signature of Local Health Officer: <i>Susan W. Best, D.O.</i>				49. For Registrar Only - Date Filed (Month/Day/Year): <i>December 30, 2008</i>					