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TICOR TITLE INSURANCE

2010 058085

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Craig E. McClory, being first duly
sworn upon oath, deposes and says:

1. That Rachelle Goodwin-McClory died on
July 16, 2003, 1903 at Crown Point, Ind.

2. That Craig E. McClory and Rachelle Goodwin-McClory
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate:

1345 Westbrook Drive, Crown Point, Indiana 46307

Legal description:

Lot 21 in Brookside Phse No.1, as per plat thereof, recorded in Plat Book
79 page 96, and amended by Certificate of Correction recorded July 19, 1996, as
Document No. 96048147, and further amended by Certificate of Correction recorded
January 28, 1997, as Document No. 97005339, in the Office of the Recorder of Lake
County, Indiana. 45-16-04-202-001.006-042

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 ~~XXXX~~ (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.

FILED
SEP 29 2010

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Craig E. McClory

Subscribed and sworn to before me, a Notary Public, this 22nd day of
September, XX 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." Chris Burk

Philip J. Ignarski
Notary Public.

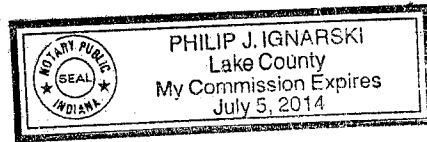
My Commission expires:

07-05-14

County of Residence:

Lake

This Instrument prepared by Craig E. McClory



029574

FN
14⁰⁰
13

FIDELITY CP

920106263

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1752-03

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Rachelle L. Goodwin-McClory		2 SEX F	3a TIME OF DEATH 10:30 A M	3b DATE OF DEATH (Month, Day, Yr) July 16, 2003	
4 *SOCIAL SECURITY NUMBER [REDACTED]-0250	5a AGE—Last Birthday (Years) 33	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) 5/25/70	
7 BIRTHPLACE (City and State or Foreign Country) Mt. Holly, NJ	9a 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 type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				
8a WAS DECEDENT A U.S. VETERAN? N	8b YEAR LAST SERVED IN U.S. ARMED FORCES? --	9b FACILITY NAME (If not institution, give street and number) 1345 Westbrook Dr.			
9c CITY, TOWN, OR LOCATION OF DEATH Crown Point		9d COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) M	11 SURVIVING SPOUSE (If wife, give maiden name) Craig E. McClory	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Computer Consultant	12b KIND OF BUSINESS/INDUSTRY Self-employed		
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Crown Point	13d STREET AND NUMBER 1345 Westbrook Dr.		
13e ZIP CODE 46307	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) W	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		17. DECEDENT'S EDUCATION			
18 FATHER'S NAME (First, Middle, Last) Vincent John Goodwin		19 MOTHER'S NAME (First, Middle, Maiden Surname) Nancy C. Akland			
20a INFORMANT'S NAME (Type/Print) Craig McClory		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1345 Westbrook Dr., Crown Point, IN 46307		20c Relationship Husband	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) July 18, 2003 N. W. Indiana Cremation Svcs.		21c LOCATION—City or Town, State Crown Point, IN	
22a EMBALMER'S NAME N/A		22b EMBALMER'S LICENSE NO. N/A		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) 1009461		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445	
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. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>cardiomyopathy of heart</i> <i>time 10:30 AM</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. _____ DUE TO (OR AS A CONSEQUENCE OF):					
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) N		28a WAS AN AUTOPSY PERFORMED? (Yes or no) N		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 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) as stated.					
29b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>			29c MEDICAL LICENSE NO. 01020846	29d DATE SIGNED (Month, Day, Year) 7/18/03	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Donald Phillips, 1356 S. Lake Park, Hobart, IN 46342					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month, Day, Year) July 24, 2003		
33 MANNER OF DEATH <input 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)	34e THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT DESCRIPTION OF THE CAUSE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. JUL 24 2003
		34d 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) JUL 24 2003	
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			