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AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:
Tax I.D. No. 45-12-09-129-009.000-030

COMMUNITY TITLE CO.
3870 WEST 80TH LANE
MERRILLVILLE, IN 46410

2014 048916

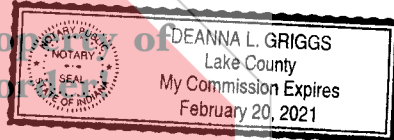
BRENT D. JEWELL, being first duly sworn upon oath, deposes and says:

1. That **ORVILLE STEWART JEWELL a/k/a ORVILLE S. JEWELL** died on the 25th day of August, 2007 in Lake County, Indiana.
2. That at the time of his death, he held a Life Estate interest in the following described real estate:
LOT 10, IN ENGLEHART'S COUNTRY CLUB MANOR (ROSS TOWNSHIP) AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 24, PAGE 75, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

3. That no Federal Estate Tax or Indiana Inheritance Tax is due as a result of the death of **ORVILLE STEWART JEWELL a/k/a ORVILLE S. JEWELL**.
4. That this Affiant's relationship to the Decedent was cousin.

FURTHER, Affiant saith naught.

Brent D. Jewell
BRENT D. JEWELL



Subscribed and sworn to before me, a Notary Public this 7 day of August, 2014.

Deanna L. Griggs, Notary Public

My Commission Expires: 2.20.21
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.

Deanna L. Griggs
Signature of Preparer

Deanna L. Griggs
Name of Preparer

This instrument prepared by **PATRICK J. McMANAMA**, Attorney at Law, Attorney ID No. 9534-45. No legal opinion given or rendered. All information and preparation of document was supplied by title company.

FILED
AUG 13 2014
1146202
03432

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

14.
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DN
work copy

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

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 INK

PRECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) ORVILLE STEWART JEWELL				2. SEX Male	3a. TIME OF DEATH 6:10 A M	3b. DATE OF DEATH (Month, Day, Year) August 25, 2007	
4. SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE—Last Birthday (Years) 88	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) April 8, 1919	7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana		
8. A U.S. VETERAN? Yes	9. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		9a. PLACE OF DEATH (Check only one. See instructions.) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence Hospice			
9b. FACILITY NAME (If not institution, give street and number) 1009 W. 63rd Avenue			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) Daisy Rukavina		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during part of working life. Do not use retired) Pipfitter		12b. KIND OF BUSINESS/INDUSTRY Steel Industry		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Merrillville		13d. STREET AND NUMBER 1009 W. 63rd Avenue			
13e. ZIP CODE 46410	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) White		
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+)					
18. FATHER'S NAME (First, Middle, Last) Edward Everett Jewell				19. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Augusta Stibbe			
20a. INFORMANT'S NAME (Type/Print) Daisy Jewell			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 1009 W. 63rd Avenue Merrillville, IN 46410		20c. Relationship Wife		
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) August 28, 2007 Community Cremation Service			21c. LOCATION—City or Town, State Schererville, Indiana		
22a. EMBALMER'S NAME: -		22b. EMBALMER'S LICENSE NO. -		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mesarch</i>		24b. LICENSE NUMBER (of Licensee) FDO1005912		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home Inc. FH83007762 7905 Broadway Merrillville, IN 46410			
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. Sepsis Lung Cancer				Approximate Interval Between Death and Reporting AUG 30 2007			
IMMEDIATE CAUSE (Final disease or condition resulting in death) Conditions, if any, which give rise to the immediate cause, stating the underlying cause last				THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT.			
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? No	
				28b. WERE AUTOPSY FINDINGS AVAILABLE FOR THE COMPLETION OF CAUSE OF DEATH? (Yes or No) No			
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) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kalash</i>				29c. MEDICAL LICENSE NO. 01037891		29d. DATE SIGNED (Month, Day, Year) 8-30-07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Surya Nallari M.D. 404 10th Street Demotte, IN 46310							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W But. DO.</i>					32. DATE FILED (Month, Day, Year) August 30, 2007		
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)	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.				