

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

AFFIDAVIT OF SURVIVORSHIP

766906

Berniece Slankard, being first duly sworn upon her oath, deposes and says as follows:

1. That this affidavit is made with reference to the following described real estate, to-wit:

Lot Thirteen (13), Block One (1), Cedarcrest Subdivision, as shown in Plat Book 31, page 99, and as re-recorded in Plat Book 32, page 93, in Lake County, Indiana.

2. That your affiant is the widow of the deceased and is familiar with the affairs of the said David Slankard and the estate of such deceased.

3. That the said David Slankard died on April 26, 1984, resident of Cedar Lake, Lake County, Indiana, and his residence at the time of his death was 14125 Parrish, Cedar Lake, Indiana.

4. That the decedent died leaving a Last Will and Testament but that the decedent left no assets subject to probate administration; that the decedent's estate including the above-described real estate was not subject to Federal Estate Tax.

5. That the said David Slankard and Berniece Slankard were husband and wife at the time they acquired title to the above-described real estate and remained so until the death of the said David Slankard.

Further Your Affiant Saith Not.

Berniece Slankard  
BERNIECE SLANKARD  
Auditor Lake County

JUL 30 1984

Subscribed and sworn to before me, a Notary Public, on this 25<sup>TH</sup> day of July, 1984.

Marguerite A. Scheraga  
Notary Public: Marguerite A. Scheraga

My Commission Expires:  
June 11, 1987

Lake County Resident

Prepared by: David J. Sims, Attorney at Law  
P.O. Box 88  
11108 W. 133rd Avenue  
Cedar Lake, IN 46303

STATE OF INDIANA/S.S. NO.  
LAKE COUNTY  
FILED FOR RECORD  
JUL 31 11 37 AM '84  
WILLIAM B. STANLEY JR.  
RECORDER

FILED

NOTARY PUBLIC  
MARGUERITE A. SCHERAGA  
LAKE COUNTY, INDIANA

MAIL 40;

001397

5-50

TYPE OR PRINT  
PLAINLY WITH  
UNFADING INK  
THIS IS A  
PERMANENT  
RECORD

Below for State Office Use

- A \_\_\_\_\_
- B \_\_\_\_\_
- C \_\_\_\_\_
- D \_\_\_\_\_
- E \_\_\_\_\_
- F \_\_\_\_\_
- G \_\_\_\_\_
- 5 THIS CERTIFIES THE APPROVED AGENCY HAS  
COMPLETE COPY OF THE CERTIFICATE OF  
DEATH ON FILE WITH THE LAKE COUNTY  
HEALTH DEPT. APR 27 1984
- 6 Reg # 24 143-13  
Cedarvale Ind  
2.13 B.C. 1
- 7
- 8
- 9
- 10
- 11
- 12

FUNERAL HOME No. \_\_\_\_\_  
 FUNERAL DIRECTOR'S LICENSE No. \_\_\_\_\_  
 EMBALMER'S NAME \_\_\_\_\_  
 FUNERAL DIRECTOR'S SIGNATURE \_\_\_\_\_  
 LAKE COUNTY HEALTH COMMISSIONER \_\_\_\_\_

Local No. 722-84

## INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

State No. \_\_\_\_\_

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK  
 DECEASED  
 USUAL RESIDENCE WHERE DECEASED LIVED & DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION  
 PARENTS  
 DISPOSITION  
 M.D. OR D.O.  
 CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST  
 CAUSE

DECEASED—NAME 1 <b>David Slankard</b>			SEX 2 <b>Male</b>	DATE OF DEATH (MONTH DAY YEAR) <b>April 26, 1984</b>	
RACE—(e.g. White, Black, American Indian, etc.) (Specify) 4 <b>White</b>	AGE—Last Birthday 5a <b>63</b>	UNDER 1 YEAR 5b MONTHS	UNDER 1 DAY 5c HOURS MIN.	DATE OF BIRTH (Mo. Day Yr.) 6 <b>Jan. 10, 1921</b>	COUNTY OF DEATH 7a <b>Lake</b>
CITY, TOWN OR LOCATION OF DEATH 7b <b>Crown Point</b>		HOSPITAL OR OTHER INSTITUTION—Name (if not in other give street and number) 7c <b>St. Anthony's Medical Center</b>		IF HOSP. OR INST. Indicate DOA OF _____ 7d <b>Emergency</b>	
STATE OF BIRTH (If not in U.S.A. name country) 8 <b>Illinois</b>	CITIZEN OF WHAT COUNTRY 9 <b>U.S.A.</b>	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10 <b>Married</b>	SURVIVING SPOUSE (If wife, give maiden name) 11 <b>Berniece Bundren</b>	WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) 12 <b>Yes</b>	
SOCIAL SECURITY NUMBER 13 <b>317-16-6361</b>		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a <b>Laborer</b>	KIND OF BUSINESS OR INDUSTRY 14b <b>Foundry</b>		
RESIDENCE—STATE 15a <b>Indiana</b>	COUNTY 15b <b>Lake</b>	CITY, TOWN OR LOCATION 15c <b>Cedar Lake, Ind</b>			
STREET AND NUMBER 15d <b>14125 Parrish</b>			IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	INSIDE CITY LIMITS (Specify Yes or No) 15f <b>Yes</b>	
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN, CUBAN, PUERTO RICAN, ETC 15g YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>JUL 30 1984</b>		
FATHER—NAME 16 <b>David Slankard</b>		MOTHER—MAIDEN NAME <b>Pearl Burris</b>			
INFORMANT—NAME (Type or Print) 18a <b>Berniece Slankard Wife</b>		RELATIONSHIP <b>Wife</b>	MAILING ADDRESS—STREET OR R.F.D. NO. 18b <b>14125 Parrish</b>	CITY OR TOWN <b>Cedar Lake, Indiana</b>	STATE ZIP <b>46303</b>
BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a <b>Burial</b>		CEMETERY OR CREMATORY—FUNERAL HOME 19b <b>Chapel Lawn</b>	LOCATION CITY OR TOWN STATE 19c <b>Schererville, Indiana 46303</b>		
DATE (MONTH DAY YEAR) 20a <b>April 30, 1984</b>		FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN STATE ZIP) 20b <b>Eller Brady 8510 Lakeshore Dr., Cedar Lake, Ind.</b>			
To the best of my knowledge, death occurred at the time, date and place and give to the causal stated 21a (Signature) <b>R. W. King M.D.</b>		DATE SIGNED (Mo. Day Yr.) 21b <b>4/27/84</b>	HOUR OF DEATH 21c <b>8:30 P M</b>		
NAME OF ATTENDING PHYSICIAN (Type or Print) 21d <b>Robert W. King, M.D.</b>		MAILING ADDRESS—PHYSICIAN 21e <b>13301 Lincoln Plaza - Cedar Lake, Indiana 46303</b>			
HEALTH OFFICER—SIGNATURE 22a <b>[Signature]</b>			DATE RECEIVED BY LOCAL HEALTH OFFICER 22b <b>4-27-84</b>		
PART I (a) <b>Cardiac-pulmonary failure</b>		IMMEDIATE CAUSE (NEVER ONLY ONE CAUSE PER LINE FOR (a) AND (b))		Interval between onset and death <b>1 day</b>	
(b) <b>Toxemia</b>		DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death <b>1 week</b>	
(c) <b>Carcinomatous of Adenocarcinoma Prostate</b>		DUE TO OR AS A CONSEQUENCE OF		Interval between onset and death <b>3 mo.</b>	
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not stated to cause given in PART I (a)		AUTOPSY (Specify Yes or No) 24			

1397A