



SURVIVORSHIP AFFIDAVIT

STATE OF Indiana } S. S.
COUNTY OF Lake

On this May 30, 1995 before me personally appeared _____
(insert date)

Jeanette E. Schoop

to me personally known, who being duly sworn on oath did say that:

- 1. Affiant resides at the address given below affiant's signature;
- 2. Affiant is owner _____;
(state interest of affiant in the above premises as "owner," "son of owner," etc.)
- 3. Said premises were formerly owned as joint tenants or as tenants by the entireties by
Robert C. Schoop and Jeanette E. Schoop

4. Said Robert C. Schoop _____
(fill in name of co-tenant who died)

died on October 23, 1993

leaving no will;
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:
Lots 15 and 16, E.W. Sohl's Fifth Addition, in the City of Hammond, shown in Plat Book 2, page 95, in Lake County, Indiana.

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent:

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?
No

(If answer is "Yes," identify the divorce proceedings: _____);

8. Affiant's relationship to the deceased was Wife

Signature: Jeanette E. Schoop
Jeanette E. Schoop

Address: 843 176th St., Hammond, IN 46324

Subscribed and sworn to before me by the affiant

this May 30, 1995
(insert date)

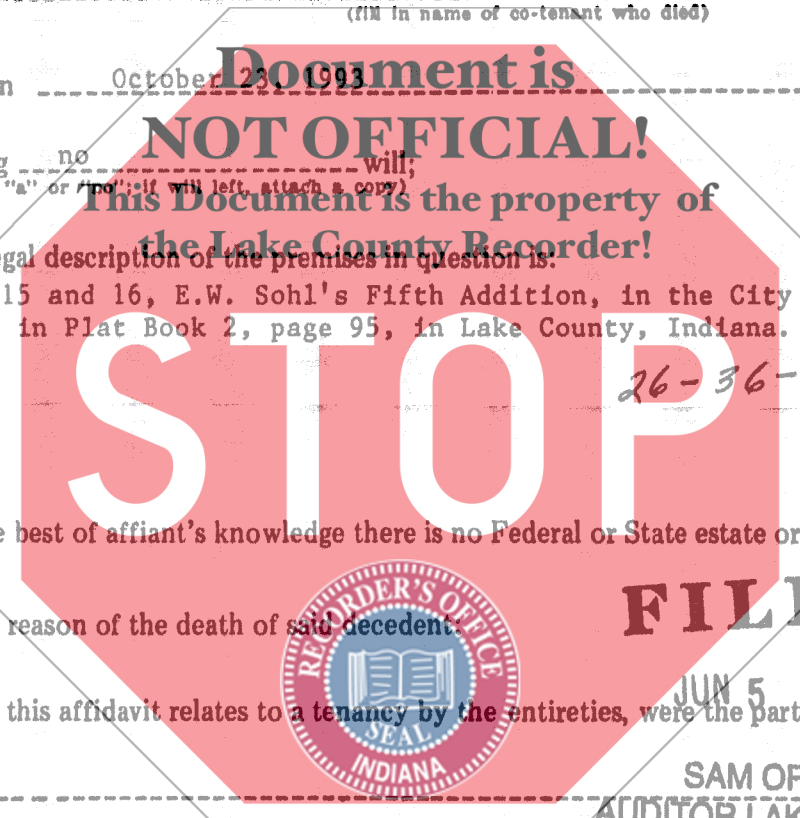
Jacqueline C. Conroy
Jacqueline C. Conroy, Notary Public

My Commission Expires 3/11/96

This instrument prepared by Clement B. Knapp, Jr., Attorney at Law

Chicago Title Insurance Company

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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
JUN -6 AM 10:07
26-36-54
RECORDED

FILED

JUN 5 1995

SAM ORLICH
AUDITOR LAKE COUNTY

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INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2494-93

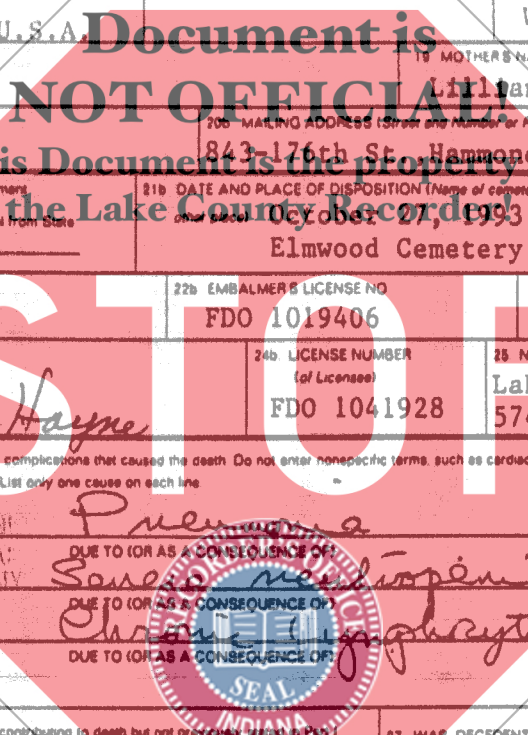
CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

**TYPE/PRINT
IN
PERMANENT
BLACK INK**

1 DECEASED—NAME (First Middle Last) ROBERT C. SCHOOP		2 SEX MALE	3a TIME OF DEATH 6:15P M	3b DATE OF DEATH (Month Day Yr) OCTOBER 23, 1993	
4 SOCIAL SECURITY NUMBER 316-42-4330	5a AGE—Last Birthday (Years) 49	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) July 8, 1944	
7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana		8a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> NOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8a WAS DECEDENT A US VETERAN? NO	8b YEAR LAST SERVED IN US ARMED FORCES?	9a FACILITY NAME (If not institution give street and number) THE COMMUNITY HOSPITAL	9c CITY TOWN OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Jeanette E. De Groot	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Owner	12b KIND OF BUSINESS/INDUSTRY B/H Enterprise		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond	13d STREET AND NUMBER 843-176th St.		
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) 1		18 FATHER'S NAME (First Middle Last) Conrad L. Schoop			
19 MOTHER'S NAME (First Middle Maiden Surname) Lillian Hansen		20a INFORMANT'S NAME (Type/Print) Jeanette E. Schoop			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 843-176th St., Hammond, Indiana 46324		20c Relationship Wife			
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <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 facility) October 27, 1993 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, Indian	
22a EMBALMER'S NAME Henry Blake		22b EMBALMER'S LICENSE NO. FDO 1019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Elden V. LaHayne</i>		24b LICENSE NUMBER (of Licensee) FDO 1041928		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc. FH 83002885 5746 Hohman Ave., Hammond, IN. 46320	
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. Pneumonia DUE TO (OR AS A CONSEQUENCE OF) Sepsis DUE TO (OR AS A CONSEQUENCE OF) Chronic lymphocytic DUE TO (OR AS A CONSEQUENCE OF)				Approximate Interval Between Onset and Death	
26 PART II Other significant conditions - Conditions contributing to death but not proximately related to Part I. <i>Chronic lymphocytic</i>					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input type="checkbox"/>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) SAM ORLIC	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>Salman D. Gailani</i>			
29c MEDICAL LICENSE NO. 27970		29d DATE SIGNED (Month, Day, Year) OCTOBER 25, 1993			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) SALMAN D. GAILANI, MD 9116 COLUMBIA AVENUE MUNSTER, IN 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Salman D. Gailani MD</i>				32 DATE FILED (Month, Day, Year) October 25, 1993	
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.			



Chicago Title Insurance Company

FILED

JUN 5 1995

**SAM ORLIC
AUDITOR LAKE COUNTY**

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