Chicago Title Insurance Company

am Savings FSB 480542 480542 pkg 4028

SURVIVORSHIP AFFIDAVIT

2

STATE OF Indiana
COUNTY OF Lake } S. S.

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

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, as shown in Plat Book 2, page 95, in Lake County, Indiana.

26-36-54-B

95031743

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
95 JUN -5 AM 10:07
RECORDER

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.

FILED
JUN 5 1995
SAM ORLICH
AUDITOR LAKE COUNTY

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

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

Subscribed and sworn to before me by the affiant

this May 30, 1995 (insert date)

Jacqueline C. Coy Notary Public

My Commission Expires 3/11/96

000230

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

Chicago Title Insurance Company

$00

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2494-93 — **CERTIFICATE OF DEATH** — State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
ROBERT C. SCHOOP	MALE	6:15P M	OCTOBER 23, 1993

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR (Months / Days)	5c UNDER 1 DAY (Hours / Minutes)	6 DATE OF BIRTH (Mo. Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
316-42-4330	49			July 8, 1944	Hammond, Indiana

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
NO		HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Jeanette E. De Groot	Owner	B/H Enterprise

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	843-176th St.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16 RACE—American Indian, Black, White, etc. (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
46324	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Conrad L. Schoop	Lillian Hansen

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
Jeanette E. Schoop	843-176th St. Hammond, Indiana 46324	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)	October 27, 1993 Elmwood Cemetery	Hammod, Indian

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Henry Blake	FDO 1019406	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Elden V. LaHayne	FDO 1041928	LaHayne Funeral Home, Inc. FH 83002885 5746 Hohman Ave., Hammond, IN. 46320

CAUSE OF DEATH

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. Pneumonia	
DUE TO (OR AS A CONSEQUENCE OF)	b. Severe Medullopenia	
DUE TO (OR AS A CONSEQUENCE OF)	c. Chronic Lymphocytic	
DUE TO (OR AS A CONSEQUENCE OF)	d.	

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

OCT 25 1993

PART II Other significant conditions - Conditions contributing to death but not previously listed in PART I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
(no)		

FILED JUN 5 1995 SAM ORLICH AUDITOR LAKE COUNTY

CERTIFIER

29a CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.

[ ] 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.

[ ] 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day, Year)
Salman Gailani	27970	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

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Salman Gailani MD	October 25, 1993

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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)
	00031

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.