Chicago Title Insurance Company

H 483584CO

1

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
COUNTY OF LAKE } S. S.

On this January 18, 1996 (insert date) before me personally appeared

DAVID GARDNER

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 son of the owners; (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 F. Gardner and Edna Ruth Gardner;

4. Said Robert F. Gardner (fill in name of co-tenant who died)

   died on May 22, 1988

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

5. The legal description of the premises in question is:

   Lot 6, Block 5, Hessville Gardens, in the City of Hammond, as shown in Plat Book 16, Page 27, 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 son.

Signature: David P. Gardner
DAVID P. GARDNER
Address: 7232 Grand Avenue
Hammond, IN 46323

Subscribed and sworn to before me by the affiant

this January 18, 1996 (insert date)

Richard S. Tibik
RICHARD S. TIBIK Notary Public

My Commission Expires 7/3/97

This instrument prepared by David P. Gardner

Chicago Title Insurance Company

96012844

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 FEB 28 AM 10:18
MARSHA G... RECORDER

FILED
FEB 27 1996
SAM ORLICH
AUDITOR LAKE COUNTY

001387

11.00 CK
SN

2

Local No. 462

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAY 24 1988 — Date Issued
[signature] — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: First: ROBERT; Middle: F.; Last: GARDNER
2 SEX: MALE
3 DATE OF DEATH (Mo Day Yr): MAY 22, 1988
4 SOCIAL SECURITY NUMBER: 312-10-8489
5a AGE—Last Birthday (Years): 81
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Month Day Year): Sept. 18, 1906
7 BIRTHPLACE (City and State or Foreign Country): Knightstown, Indiana
8 YEAR LAST SERVED IN US ARMED FORCES? 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution give street and number): St. Margaret Hospital
9c CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife give maiden name): Edna Potts
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Crane Operator
12b KIND OF BUSINESS/INDUSTRY: Inland Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Hammond
13d STREET AND NUMBER: 6624 Alabama Avenue
13e INSIDE CITY LIMITS? (Yes or no): yes
13f FARM: no
13g ZIP CODE: 46323
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes specify Cuban, Mexican, Puerto Rican etc.) ☐ No ☐ Yes Specify: NO
15 RACE—American Indian, Black, White etc (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): secondary; College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First Middle Last): Carney Gardner
18 MOTHER'S NAME (First Middle Maiden Surname): unavailable

INFORMANT

19a INFORMANT'S NAME (Type/Print): Mrs. Edna Gardner (Wife)
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6624 Alabama Avenue Hammond, Indiana 46323
19c Relationship: WIFE

DISPOSITION

20a METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 25, 1988 Chapel Lawn Memorial Gardens
20c LOCATION—City or Town, State: Schererville, Indiana
21a SIGNATURE OF FUNERAL DIRECTOR: [signature]
21b LICENSE NUMBER (of Licensee): FDE1C13507
22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FDH3002801, 7042 Kennedy Avenue Hammond, Indiana 46323

PRONOUNCING PHYSICIAN ONLY

23a To the best of my knowledge death occurred at the time, date and place stated. Signature and Title:
23b LICENSE NUMBER:
23c DATE SIGNED (Month Day Year):

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 7:50p.m.
25 DATE PRONOUNCED DEAD (Month Day Year): May 22, 1988
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no): no

CAUSE OF DEATH (SEE INSTRUCTIONS)

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. ACUTE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF)
b. ACUTE RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF)
c. DEHYDRATION
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a WAS AN AUTOPSY PERFORMED? (Yes or no): no
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED FEB 2 1990 — AUDITOR LAKE COUNTY

CERTIFIER (SEE INSTRUCTIONS)

29a CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23). To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death). To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c LICENSE NUMBER: 01035201
29d DATE SIGNED (Month Day Year): May 23, 1988
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Cynthia J. Sanders, M.D. 7905 Calumet Avenue Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] M.D.
32 DATE FILED (Month Day Year): MAY 24 1988

CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
34a DATE OF INJURY (Month Day Year):
34b TIME OF INJURY:
34c INJURY AT WORK? (Yes or no):
34d DESCRIBE HOW INJURY OCCURRED: 001388
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):

SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1