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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

STATE OF INDIANA  
COUNTY OF LAKE

97022175

97 APR 11 AM 10:29

MUNSTER CENTER  
RECORDER

**A F F I D A V I T**

VIOLET B. JOHNSON, being first duly sworn upon her oath, deposes and says as follows:

1. That the affiant and Roy H. Johnson were Co-Trustees of the ROY H. JOHNSON and VIOLET B. JOHNSON REVOCABLE TRUST AGREEMENT and the owners of the following described real estate:

Lot 11, Corrected Plat of Plum Creek Addition to the Town of Munster, as shown in Plat Book 44, page 9, and as amended by Certificate of Correction filed January 16, 1974, in Plat Book 44, page 21, in Lake County, Indiana.

2. That Roy H. Johnson died a resident of Lake County, Indiana on February 21, 1997, as evidenced by the Certificate of Death attached hereto as Exhibit "A", and that no probate proceedings have been commenced nor are any contemplated.

4. That the total assets of Roy H. Johnson were insufficient for Federal estate tax filing purposes.

FURTHER AFFIANT SAITH NOT.

**FILED**

APR 10 1997

SAM ORLICH  
AUDITOR LAKE COUNTY

*Violet B. Johnson*  
VIOLET B. JOHNSON

SUBSCRIBED AND SWORN to before me, a Notary Public, this 28<sup>th</sup> day of March, 1997.

*Kathleen L. Teeling*  
Kathleen L. Teeling, Notary Public

My Commission Expires:  
12/12/98

County of Residence:  
Lake

000598

This instrument prepared by: WILLIAM J. MORAN/ID #10641-41  
9006 Indianapolis Boulevard  
Highland, Indiana 46322  
(219) 838-1333

11.00  
6947

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

INDIANA STATE DEPARTMENT OF HEALTH

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

Local No. 150

CERTIFICATE OF DEATH

Feb. 24, 1997 Date Issued Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRI. IT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

1 DECEASED—NAME (First Middle Last) Roy Harry Theodore Johnson				2 SEX Male		3a TIME OF DEATH 11:40 a.m.		3b DATE OF DEATH (Month Day Year) February 21, 1997	
4 SOCIAL SECURITY NUMBER 353-16-0738		5a AGE—Last Birthday (Years) 74		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo. Day, Yr.) December 14, 1922	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL		8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) St. Margaret Hospital				9b CITY, TOWN OR LOCATION OF DEATH Hammond			9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Violet Sponberg		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Aneler			12b KIND OF BUSINESS/INDUSTRY Steel		
13a RESIDENCE—STATE IN		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Munster			13d STREET AND NUMBER 9000 Chestnut Ln		
13e ZIP CODE 46321		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? XX 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) College (1-4 or 5+) 12		18 FATHER'S NAME (First Middle Last) Theodore Johnson				19 MOTHER'S NAME (First Middle Maiden Surname) Signe Johanson			
20a INFORMANT'S NAME (Type/Print) Violet Johnson				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Chestnut LN, Munster, IN 46321				20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input 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) February 25, 1997 Oak Hill Cemetery				21c LOCATION—City or Town State Chicago, IL	
22a EMBALMER'S NAME James Porras				22b EMBALMER'S LICENSE NO. 1045964		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>James Porras</i>				24b LICENSE NUMBER (of Licensee) 8601763		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish FH 8415 Calumet Ave Munster, IN 46321 #3004968			
26 PART I: Enter the disease, 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. IMMEDIATE CAUSE (final disease or condition resulting in death) SEPSIS DUE TO (OR AS A CONSEQUENCE OF) PNEUMONIA -> ASPIRATION. CONDITIONS IF ANY WHICH GAVE RISE TO THE IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST CANDIDEMIA DUE TO (OR AS A CONSEQUENCE OF) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART II: Other significant conditions: Conditions contributing to death but not previously stated in Part I DEEP VEIN THROMBOSIS ARRHYTHMIC FIBRILLATION.									
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No						28a WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N.A.	
29 I hereby certify that I am a duly qualified health officer at the time, date and place and due to the cause(s) as stated.									
30 I hereby certify that I am a duly qualified health officer at the time, date and place and due to the cause(s) as stated.									
31 I hereby certify that I am a duly qualified health officer at the time, date and place and due to the cause(s) and manner as stated.									
32a SIGNATURE OF HEALTH OFFICER <i>James S. Hammond, M.D.</i>						32b MEDICAL LICENSE NO. 44812		32c DATE SIGNED (Month Day Year) (Feb) 2/21/97	
33 HEALTH OFFICER'S RESIDENCE 110 RIDGE ROAD MUNSTER IN 46321									
34 HEALTH OFFICER'S SIGNATURE <i>James S. Hammond, M.D.</i>									
32 DATE FILED (Month Day Year) February 24, 1997									
34a 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			34b DATE OF DEATH (Month Day Year)		34c TIME OF DEATH		34d INJURY AT WORK? (Yes or no)		34e DESCRIBE HOW INJURY OCCURRED
34f PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) (Specify)				34g LOCATION (Street and Number or Rural Route Number, City or Town, State)					
34h DATE PROHOUNCED DEAD (Month Day Year)			34i MOTOR VEHICLE ACCIDENT? (Yes or no). If yes specify if driver, passenger, pedestrian, etc.						

