

FA 20189

FILED

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA)

APR 24 1997

COUNTY OF LAKE)

SS: 97025682

97 APR 24 AM 11:02

) SAM ORLICH
AUDITOR LAKE COUNTY
AFFIDAVIT OF SURVIVORSHIP

MORRIS W. CARTER
RECORDER

HOLD FOR FIRST AMERICAN TITLE

Comes now JOSEPH W. GASS, who, being first duly sworn upon his oath, deposes and states as follows.

1. I, Joseph W. Gass, am the surviving spouse of Wanda M. Gass, and together as husband and wife, we held as tenants by the entirety the following described Real Estate located in Lake County, Indiana, which is more particularly described as follows:

The North 30 feet of Lot 95 and the South 15 feet of Lot 94 in White Oak Avenue Addition to Hammond as per Plat thereof, recorded in Plat Book 16, page 19, in the Office of the Recorder of Lake County, Indiana.

Tax Key Number: 36-325-35

(Commonly known as: 4828 Birch Street, Hammond, Indiana.)

Said property is hereinafter referred to as the "Real Estate."

2. Wanda M. Gass and I were husband and wife at the time we acquired title to the Real Estate as tenants by the entirety on or about October 20, 1953, under a deed recorded on November 16, 1953, as Document No. 720450, in Deed Record Book 952, page 104, in the Office of the Recorder of Lake County, Indiana.

3. The marital relationship between Wanda M. Gass and I existed from the date we acquired title to the Real Estate and continued unbroken from that time until the death of Wanda M. Gass in Lake County, Indiana on May 13, 1996, at which time I acquired sole title to the Real Estate as surviving tenant by the entirety.

4. That the transfer of the Real Estate to myself, as the surviving spouse of Wanda M. Gass, is a transaction that is exempt from taxation for purposes of either Federal Estate Taxes or Indiana Inheritance or Death Taxes, and no such taxes were due as a result of the death of Wanda M. Gass and the transfer of her interest in the Real Estate to myself; nor was the Real Estate subject to any claims against the estate of said Wanda M. Gass.

5. This Affidavit is made for the purpose of inducing any person or taxing authority into relying on the rights and ownership of myself, Joseph W. Gass, to said Real Estate as provided by law, to clear title to said Real Estate, and to enable the Auditor of Lake County, Indiana to transfer on its records ownership of the above described real estate for the purposes of taxation.

for
1997

Further the Affiant saith naught.

So stated on this 16th day of April, 1997.

Joseph W. Gass
Joseph W. Gass, Affiant

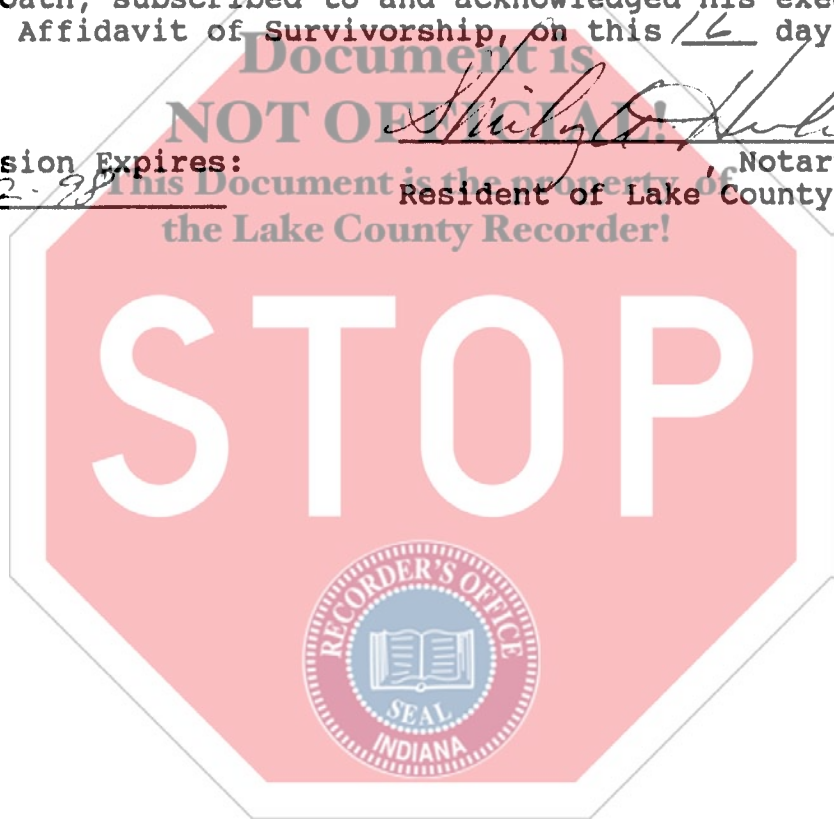
ACKNOWLEDGEMENT

Before me, a Notary Public in and for the County of Lake, State of Indiana, personally appeared, Joseph W. Gass, personally known by me to be the person who, having been first duly sworn upon his oath, subscribed to and acknowledged his execution of the foregoing Affidavit of Survivorship, on this 16 day of April, 1997.

My Commission Expires:

1-2-98

Shirley A. Hill
Notary Public
Resident of Lake County, Indiana



THIS INSTRUMENT PREPARED BY: Patrick A. Mysliwy,
Attorney No. 10002-45, of MAISH & MYSLIWY, Attorneys at Law,
5248 Hohman Avenue, Suite 200, Hammond, Indiana 46320

* 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

CERTIFICATE OF DEATH

State No.

Local No. 1057-96

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First Middle Last) Wanda M. Gass		2 SEX Female	3a TIME OF DEATH 07:57P	3b DATE OF DEATH (Month Day, Yr) May 13, 1996	
4 SOCIAL SECURITY NUMBER 358-22-0400	5a AGE—Last Birthday (Yr/Mo/D) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) Sep 17, 1922	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL	8a PLACE OF DEATH (Check only one See instructions)				
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			
9a FACILITY NAME (If not institution, give street and number) St Anthonys Hospital		9b CITY, TOWN OR LOCATION OF DEATH Crown Point	9c COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Joseph W. Gass	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker	12b KIND OF BUSINESS/INDUSTRY Own Home		
13a RESIDENCE—STATE IN	13b COUNTY Newton	13c CITY, TOWN OR LOCATION Lake Village	13d STREET AND NUMBER 7405 N. 700 W.		
13e ZIP CODE 46349	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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)		17a ELEMENTARY/SECONDARY (0-12) 12			
17b COLLEGE (1-4 or 5+)					
18 FATHER'S NAME (First Middle Last) Androro Ciba		19 MOTHER'S NAME (First Middle Maiden Surname) Helen Pagrazinski			
20a INFORMANT'S NAME (Type/Print) Joseph W. Gass		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7405 N. 700 W. Lake Village, IN 46349		20c Relationship Husband	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) May 17, 1996 Lake Village Cemetery		21c LOCATION—City or Town, State Lake Village, IN	
22a EMBALMER'S NAME Kenneth P. Sheets		22b EMBALMER'S LICENSE NO. FD08900045		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Kenneth P. Sheets</i>		24b LICENSE NUMBER (of Licensee) FD08900045		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN	
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.					
IMMEDIATE CAUSE OF DEATH (Disease or condition resulting in death) Gas to intestinal bleeding					
DUE TO (OR AS A CONSEQUENCE OF) Peptic ulcer disease					
DUE TO (OR AS A CONSEQUENCE OF) DK-II Malabsorption					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs					
DATE OF DEATH MAY 21 1996					
COUNTY HEALTH COMMISSIONER APR 24 1997					
27 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I DK-II Malabsorption		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		28a WAS AN AUTOPSY PERFORMED? NO	
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO SIGNATURE OF CAUSE OF DEATH? (Yes or no)		28c WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO SIGNATURE OF CAUSE OF DEATH? (Yes or no) 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>[Signature]</i>		29c MEDICAL LICENSE NO. 0200165	
29d DATE SIGNED (Month, Day, Year) 5-16-96		30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Kirby Sliker DO, 297 Franciscan Dr, Crown Point, IN 46307			
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month, Day, Year) May 21 1996		
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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
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) 001000			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			