4

STATE OF INDIANA)
) SS: **SURVIVORSHIP AFFIDAVIT**
COUNTY OF LAKE)

97085 55
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 DEC 12 AM 10:42
MORRIS W. CARTER
RECORDER
DEC 09 1997
SAM ORLICH
AUDITOR LAKE COUNTY

Comes now **MICHELLE McCALLISTER**, who being first duly sworn upon her oath, deposes and says:

(1). That she is an adult and a natural child of Mowry E. Goetz, Jr. and Gloria T. Goetz.

(2). That Mowry E. Goetz, Jr. and Gloria T. Goetz were duly married, and were husband and wife.

(3). That on February 8, 1997, Mowry E. Goetz, Jr. died, intestate, a resident of Lake County, Indiana. That a copy of his death certificate is attached hereto as Exhibit "A".

(4). That Gloria T. Goetz died March 22, 1997, a resident of Lake County, Indiana leaving a will. That a copy of her death certificate is attached hereto as Exhibit "B".

(5). That prior to their deaths, Mowry E. Goetz, Jr. and Gloria T. Goetz jointly owned property located at 1004 Coldstream Court, Crown Point, Indiana 46307, more particularly described as follows:

> Lot 20 in Lakes of the Four Seasons, Unit No. 1, as per Plat thereof, recorded July 18, 1966 in Plat Book 37 Page 63, in the Office of the Recorder of Lake County, Indiana.

(6). That Mowry E. Goetz, Jr. and Gloria T. Goetz were duly and legally married at that time they acquired title as husband and wife to said real estate, and were never divorced.

(7). That upon the death of Mowry E. Goetz, Jr., Gloria T. Goetz acquired ownership of said real estate as surviving joint owner.

COMMUNITY TITLE COMPANY
FILE NO x14308

00059 16 3194

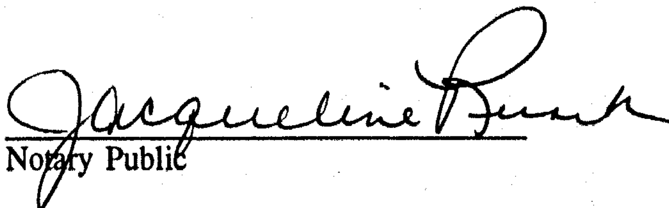
(8). That the estate of Mowry E. Goetz, Jr. was not subject to the payment of federal estate tax.

FURTHER YOUR AFFIANT SAYETH NOT.

MICHELLE McCALLISTER, Affiant

State of)
) ss:
County of)

Before me the undersigned, a Notary Public in and for said County and State personally appeared Michelle McCallister, and acknowledged the execution of this instrument this 21 day of November, 1997.



Notary Public

County of Residence: ______________

Commission Expiration: ______________

THIS INSTRUMENT PREPARED BY: GERALD M. BISHOP, ESQ.
Indiana Attorney Number: 2753-45
GRECO PERA & BISHOP
2115 West Lincoln Highway
Merrillville, IN 46410
(219) 738-2988

STATE OF FLORIDA

OFFICE of VITAL STATISTICS

CERTIFIED COPY

TYPE OR PRINT IN PERMANENT BLACK INK

LOCAL FILE NO 97-1036

CERTIFICATE OF DEATH FLORIDA

Field	Value
1 DECEDENT'S NAME (First, Middle, Last)	GLORIA THOMAS GOETZ
2 SEX	FEMALE
3 DATE OF DEATH (Month, Day, Year)	MARCH 22, 1997
4 SOCIAL SECURITY NUMBER	291-20-5834
5a AGE Last Birthday (Years)	73
6 DATE OF BIRTH (Month, Day, Year)	JULY 22, 1923
7 BIRTHPLACE (City and State or Foreign Country)	CLEVELAND, OHIO
8 WAS DECEDENT EVER IN US ARMED FORCES? (Yes or No)	NO
9a PLACE OF DEATH	Other (Specify): X DAUGHTER'S HOME
9b INSIDE CITY LIMITS? (Yes or No)	YES
9c FACILITY NAME (If not institution, give street and number)	121 ADAMS AVENUE
9d CITY, TOWN, OR LOCATION OF DEATH	CAPE CANAVERAL
9e COUNTY OF DEATH	BREVARD
10a DECEDENT'S USUAL OCCUPATION	HOUSEWIFE
10b KIND OF BUSINESS/INDUSTRY	OWN HOME
11 MARITAL STATUS	WIDOWED
12 SURVIVING SPOUSE	
13a RESIDENCE — STATE	INDIANA
13b COUNTY	LAKE
13c CITY, TOWN, OR LOCATION	CROWN POINT
13d STREET AND NUMBER	1004 COLDSTREAM
13e INSIDE CITY LIMITS?	YES
13f ZIP CODE	46307
14 WAS DECEDENT OF HISPANIC OR HAITIAN ORIGIN?	X No
15 RACE	WHITE
16 DECEDENT'S EDUCATION (College 1-4 or 5+)	4
17 FATHER'S NAME (First, Middle, Last)	RICHARD D. THOMAS
18 MOTHER'S NAME (First, Middle, Maiden Surname)	"unobtainable"
19a INFORMANT'S NAME	BARBARA GOETZ
19b MAILING ADDRESS	121 ADAMS AVENUE, CAPE CANAVERAL, FLORIDA 32902
20a METHOD OF DISPOSITION	X Removal from State
20b PLACE OF DISPOSITION	NORTH WEST INDIANA CREMATION SERVICE
20c LOCATION — City or Town, State	CROWN POINT, INDIANA
21a SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH	[signature]
21b LICENSE NUMBER (of Licensee)	2066
21c NAME AND ADDRESS OF FACILITY	BECKMAN-WILLIAMSON FUNERAL HOME, 101 N. BREVARD AVE., COCOA BEACH, FL 32931
22a To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated (Signature and Title)	[signature], MD
22b DATE SIGNED (Mo., Day, Yr)	3-25-97
22c HOUR OF DEATH	3:15 P.M
22d NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER	Dr. Galloway (Indiana)
23a 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 (Signature and Title)	
23b DATE SIGNED	
23c HOUR OF DEATH	
23d MEDICAL EXAMINER'S CASE #	
24 NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER)	ELIZABETH T. GALFO, M.D., 1849 MEDICAL DRIVE, TITUSVILLE, FLORIDA 32796
25a SUBREGISTRAR — SIGNATURE AND DATE	
25b LOCAL REGISTRAR — SIGNATURE	[signature]
25c DATE REGISTERED	MAR 26 1997

26 PART I Enter the diseases, injuries, or complications that caused the death. Do not list the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	End Stage Lung Cancer	3 months
b. DUE TO (OR AS A CONSEQUENCE OF)		
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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

FILED DEC 09 1997 SAM OPLICH AUDITOR OF COUNTY

Field	Value
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	
27a WAS AN AUTOPSY PERFORMED? (Yes or No)	NO
27b WERE AUTOPSY FINDINGS USED IN COMPLETING CAUSE OF DEATH?	
28 CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)	YES
29 IF FEMALE, WAS THERE A PREGNANCY IN THE PAST 3 MONTHS?	X NO
30a IF SURGERY IS MENTIONED IN PART I or II ENTER CONDITION FOR WHICH IT WAS PERFORMED	
30b DATE OF SURGERY	
31 PROBABLE MANNER OF DEATH (Specify) Natural, accident, suicide, homicide, or undetermined	Natural
32a DATE OF INJURY	
32b TIME OF INJURY	M
32c INJURY AT WORK?	
32d DESCRIBE HOW INJURY OCCURRED	
32e PLACE OF INJURY	
32f LOCATION	

HRS Form 512, Jan 93 (Previous Editions Obsolete)

THIS IS A CERTIFIED TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE

[signature] Manuel Garcia, M.D. MAR 26 1997 000598

BY Local Registrar for Brevard County State Registrar

WARNING: THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.

8679169

THE DOCUMENT FACE CONTAINS A MULTI-COLORED BACKGROUND AND GOLD EMBOSSED SEAL. THE BACK CONTAINS SPECIAL LINES WITH TEXT AND SEALS IN THERMOCHROMIC INK.

HRS FORM 1564 (10-96)

CERTIFICATION OF VITAL RECORD

EXHIBIT "B"

VOID IF ALTERED OR ERASED

VOID IF ALTERED OR ERASED

State of Florida Department of Health and Rehabilitative Services, Vital Statistics

25+VET

14308

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.

Local No. 0321-97

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

43503

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MOWRY EUGENE GOETZ JR.
2. SEX: MALE
3a. TIME OF DEATH: 2:40 P M
3b. DATE OF DEATH (Month, Day, Yr.): FEBRUARY 8, 1997
4. SOCIAL SECURITY NUMBER: 331-12-1966
5a. AGE—Last Birthday (Years): 75
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo. Day, Yr): MAY 18,1921
7. BIRTHPLACE (City and State or Foreign Country): WEST PENN, PA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) XXX Residence
9b. FACILITY NAME (If not institution, give street and number): 1004 COLD STREAM COURT
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): GLORIA THOMAS
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): METALLURGICAL ENGINEER
12b. KIND OF BUSINESS/INDUSTRY: INLAND STEEL CORP.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 1004 COLD STREAM COURT
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: XX No ☐ Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? XX No ☐ 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+): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last): MOWRY EUGENE GOETZ
19. MOTHER'S NAME (First, Middle, Maiden Surname): ELVIRA MAE DAVIS

INFORMANT

20a. INFORMANT'S NAME (Type/Print): GLORIA T. GOETZ
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1004 COLD STREAM CT.,CROWN POINT, IN 46307
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☐ Burial XX Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 11, 1997 NORTHWEST IND. CREMATION SERV.
21c. LOCATION—City or Town, State: CROWN POINT INDIANA
22a. EMBALMER'S NAME: N/A
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James E Burns
24b. LICENSE NUMBER (of Licensee): 1009461
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS FUNERAL HOME,10101 BROADWAY CROWN POINT, IN 46307 FDH83002445

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. Pulmonary failure
DUE TO (OR AS A CONSEQUENCE OF)
b. End Stage COPD
DUE TO (OR AS A CONSEQUENCE OF)
c. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

FILED

DEC 09 1997

SAM ORLICH
AUDITOR LAKE COUNTY

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I:

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

CERTIFIER

29a. CERTIFIER (Check only one):
XX 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: D Galloway DO
29c. MEDICAL LICENSE NO.: 02000243
29d. DATE SIGNED (Month, Day, Year): February 10, 1997

000599

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DR. DAN C. GALLOWAY, 10783 RANDOLPH,CROWN POINT, IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams MD
32. DATE FILED (Month, Day, Year): February 11, 1997

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

FEB 11 1997

Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER