2

Key 23-07-446-1

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

IN THE MATTER OF REVA ROACH, DECEASED

AFFIDAVIT OF SURVIVORSHIP

Comes now WAYNE ROACH, being duly sworn upon his oath and states as follows:

That he is the husband of the decedent, REVA ROACH, deceased, who died testate, a resident of Lake County, Indiana, on the second day of August, 1998. At the date of death, WAYNE ROACH and REVA ROACH held, as Joint Tenants, the land described below:

> Apartment #101, High Meadows Condominium, 943 High Meadows Drive, Crown Point, Indiana, as recorded as Document No. 924347 and 924348 under the date of June 24, 1987, in the Recorder's Office of Lake County, Indiana, and the undivided interest in the common elements appertaining thereto.

> Commonly known as Apartment No. 101, 943 High Meadows Drive, Crown Point, Indiana, 46322.

98072683

That the statements made in this affidavit are true and complete.

Wayne Roach
WAYNE ROACH

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, a Notary in and for the State of Indiana, personally appeared WAYNE ROACH, who acknowledged the execution of the foregoing Affidavit of Survivorship.

Witness my hand and Notary Seal this 11th day of September, 1998.

[signature]
Signature

DANIEL J SWIFT
Printed Name

County of Residence: Lake
Commission Expires: 9/26/2006

DANIEL J. SWIFT
Notary Public, State of Indiana
County of Lake
My Commission Expires 09/26/2006

1200
SH
001027C5

1

12 C

23-09-446-1

* 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

Local No. 1739-98

State No. ....

265175

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEDENT—NAME (First, Middle, Last)	Reva Roach
2. SEX	Female
3a. TIME OF DEATH	6:30P M
3b. DATE OF DEATH (Month, Day, Yr)	August 2, 1998
4. *SOCIAL SECURITY NUMBER	307-20-1309
5a. AGE—Last Birthday (Years)	73
5b. UNDER 1 YEAR (Months, Days)	
5c. UNDER 1 DAY (Hours, Minutes)	
6. DATE OF BIRTH (Mo., Day, Yr)	DEC 27, 1924
7. BIRTHPLACE (City and State or Foreign Country)	Gary, In.
8a. WAS DECEDENT A U.S. VETERAN?	No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	N/A
9a. PLACE OF DEATH (Check only one. See instructions)	HOSPITAL: ☑ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number)	St. Anthony Medical Center
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)	Wayne Roach
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	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN OR LOCATION	Crown Point
13d. STREET AND NUMBER	943 High Meadow Dr.
13e. ZIP CODE	46307
13f. INSIDE CITY LIMITS	☐ No ☑ Yes
13g. ON A FARM?	☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?	USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	☑ No ☐ Yes
16. RACE—American Indian, Black, White, etc. (Specify)	White
17. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Jesse Hulse
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Bernice Kizer

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	Wayne Roach
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	943 High Meadow Dr, Crown Point, In. 46307
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	AUG 5, 1998 Calumet Park Cemetery
21c. LOCATION—City or Town, State	Merrillville, Indiana
22a. EMBALMER'S NAME	Ronald Reed
22b. EMBALMER'S LICENSE NO.	FD01001081
23. WAS DEATH REPORTED TO CORONER?	☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	Leonard Gregorich (signature)
24b. LICENSE NUMBER (of Licensee)	FD08800305
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	FH83001253 Geisen Funeral Home, Inc. 109 N East St, Crown Point, IN46307

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. Acute Pulmonary Edema

DUE TO (OR AS A CONSEQUENCE OF):
b. Intractable Aspiration Pneumonitis

DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Obstructive Pulmonary Disease

DUE TO (OR AS A CONSEQUENCE OF):
d. Metabolic Encephalopathy

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

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

Field	Entry
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

CERTIFIED TO BE A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE ... HEALTH DEPT.

AUG 04 1998

Alexander S. Williams M.D.
COUNTY HEALTH COMMISSIONER

FILED
SEP 4 1998
SAM ORLICH
AUDITOR LAKE COUNTY

CERTIFIER

29a. CERTIFIER (Check only one)
☒ 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Bernardo S. Lucena (signature)
29c. MEDICAL LICENSE NO.	01039302
29d. DATE SIGNED (Month, Day, Year)	8/3/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Bernardo S. Lucena M. D., 1121 S. Indiana Ave., Crown Point, IN 46307

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	Alexander S. Williams MD (signature)
32. DATE FILED (Month, Day, Year)	August 4, 1998

Field	Entry
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.	

001026

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1