STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99067709

99 AUG 12 PM 12:08

MORRIS W. CARTER
RECORDER

66366

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SURVIVORSHIP AFFIDAVIT

On this 28th day of July, 1999, before me personally appeared Shirley A. Peterson 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 the owner of the following described real estate:

A parcel of land described as follows: Six rods and four feet wide off the West side of the following described piece or parcel of land described as follows: Commencing 20 rods South from the Northeast corner of the West Half of the Southeast Quarter of Section 23; Township 33 North, Range 9 West; thence South 20 rods; thence West 60 rods; thence North to the mill pond; thence Northeasterly along said pond to the North line of said Quarter Section; thence East to a point 20 rods West from the Northeast corner of said Quarter Section; thence South 20 rods; thence East 20 rods to the place of beginning, in Lake County, Indiana.

3. Said premises were formerly owned as tenants by the entireties by Shirley A. Peterson and Franklin F. Peterson.

4. Said Franklin F. Peterson died on October 2, 1996;

5. The total value of the taxable estate of said deceased including joint tenancies, tenants by the entireties, individual ownerships of both real and personal property, and insurance was nil as the undersigned affiant, as surviving widow, inherited all of the assets of the decedent and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of the decedent;

6. Where this affidavits relates to tenancy by the entireties, the parties were never divorced.

7. Affiant's relationship to the deceased was spouse.

Shirley A. Peterson

Shirley A. Peterson
261 Arrowhead Drive
Lowell, Indiana 46356

FILED

AUG 10 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

15.00

000726

Subscribed and sworn to before me by the affiant this 28th day of July, 1999.

Notary Public PENNY BRUNO
Residing in Lake County POLSTER

My Commission Expires:
8-13-99

This instrument prepared by: Donald R. O'Dell, Attorney at Law
P.O. Box 128, Lowell, IN 46356

2

* 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. 2724-96

41953

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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): Franklin F. Peterson
2 SEX: Male
3a TIME OF DEATH: 12:42A M
3b DATE OF DEATH (Month Day Yr): October 2, 1996
4 *SOCIAL SECURITY NUMBER: 507-16-2451
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): Oct 11, 1921
7 BIRTHPLACE (City and State or Foreign Country): Lowell, IN
8a WAS DECEDENT A U S VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): St. Anthony's 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): ~~None~~ Shirley Keithley
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Supervisor
12b KIND OF BUSINESS/INDUSTRY: Steel Mill
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Lowell
13d STREET AND NUMBER: 261 Arrowhead Dr.
13e ZIP CODE: 46356
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Charles Peterson
19 MOTHER'S NAME (First, Middle, Maiden Surname): Goldie Estell

INFORMANT

20a INFORMANT'S NAME (Type/Print): Shirley Peterson
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 261 Arrowhead Dr. Lowell, IN 46356
20c Relationship: Wife

DISPOSITION

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): October 5, 1996 Lowell Memorial Cemetery
21c LOCATION—City or Town, State: Lowell, IN
22a EMBALMER'S NAME: Kenneth P. Sheets
22b EMBALMER'S LICENSE NO: FD08900045
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Molly E. Sucker-Stokis
24b LICENSE NUMBER (of Licensee): FD09200061
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death) a: Myocardial Infarction — Approximate Interval Between Onset and Death: acute
b DUE TO (OR AS A CONSEQUENCE OF)
c DUE TO (OR AS A CONSEQUENCE OF)
d DUE TO (OR AS A CONSEQUENCE OF)

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

PART II Other significant 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)

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.

29b SIGNATURE AND TITLE OF CERTIFIER: Raymond J Doherty
29c MEDICAL LICENSE NO: 01016733
29d DATE SIGNED (Month, Day, Year): 10-3-96
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Raymond J. Doherty MD, 8695 Connecticut, Merrillville, IN 46410

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Trilling MD
32 DATE FILED (Month, Day, Year): October 8, 1996

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.

000727

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

OCT 08 1996

Alexander S. Trilling MD
LAKE COUNTY HEALTH COMMISSIONER

FILED AUG 10 1999
PETER BENJAMIN LAKE COUNTY AUDITOR

TYPE OR PRINT PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

1c

INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

Local No. 66-0840 State No.

1. PLACE OF DEATH a. COUNTY: Lake
b. CITY, TOWN, OR LOCATION: Gary
c. Length of Stay in 1b: 8hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mercy Hospital
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [X] NO [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Indiana b. COUNTY: Lake
c. CITY, TOWN, OR LOCATION: Lowell
d. STREET ADDRESS: 419 Michigan Ave
e. IS RESIDENCE INSIDE CITY LIMITS? YES [X] NO [ ]
f. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print) First: Goldie Middle: Mae Last: Peterson
4. DATE OF DEATH Month: June Day: 4 Year: 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 6, 1893
9. AGE (In years last birthday): 72 IF UNDER 1 YEAR Months Days IF UNDER 24 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY: U S A
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17a. INFORMANT'S NAME: Mr Franklin Peterson
17b. INFORMANT'S ADDRESS: 423 Michigan Ave Lowell Indiana
17c. RELATIONSHIP TO DECEASED: SON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion with — INTERVAL BETWEEN ONSET AND DEATH: 7 hr
Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b): myocardial infarction
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Ventricular fibrillation
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

FILED AUG 10 1966

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) CITY, TOWN, OR LOCATION COUNTY STATE

PETER BENJAMIN LAKE COUNTY AUDITOR

21. ATTENDING PHYSICIAN: I certify that I attended the deceased from June 4, 66 to June 4, 66 and last saw her alive on June 4 1966. Death occurred at 7:35 P.M. [X] E.S.T. [ ] C.S.T. on the date stated above; and to the best of my knowledge, from the causes stated.
22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at ___ M [ ] E.S.T. [ ] C.S.T. from causes stated and on above date.
23a. Signature of Attending Physician or Health Officer: [signature] MD
23b. ADDRESS: Lowell, Ind
23c. DATE SIGNED: 6-7-66

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 7 1966
24c. NAME OF CEMETERY OR CREMATORY: Lowell
24d. LOCATION: Lowell Indiana
DATE REC'D BY LOCAL HEALTH OFFICER: JUN 8 1966
SIGNATURE OF HEALTH OFFICER: [signature] Rosenbloom MD
25. FUNERAL DIRECTOR: John A. Eskridge ADDRESS: Lowell Indiana Box

000221

Below for State Office Use
A. B. C. D. E. F. G. H. I. J.
1. 2. 3. 4. 5. 6. 7. 8.

EMBALMER'S NAME: John A. Eskridge LICENSE No. 3563
FUNERAL DIRECTOR'S LICENSE No. 2023

Disposition Permit Issued / /
Provisional Certificate [ ] Yes [ ] No

S.B.H. 6-24-2 Revised 1955 U. S. Department Health, Education and Welfare Form Approved Budget Bureau No. 68-R375