

STATE OF INDIANA  
LAKE COUNTY  
FILED 10/29/99

99 NOV -8 PM 2:40

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**SURVIVORSHIP AFFIDAVIT**  
RECORDER

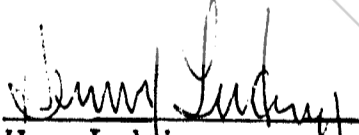
On this 29<sup>th</sup> day of October, 1999, before me personally appeared Henry Ludwig, to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature.
2. Affiant states that he is the surviving joint tenant of Sylvester N. Ludwig.
3. Affiant states that Sylvester N. Ludwig died September 15, 1999, as evidenced by her death certificate attached hereto and to be recorded along with this affidavit.
4. Said premises of the Affiant are described as follows:

The North 230 feet of the following described parcel of real estate, to-wit: Commencing at a point 2195 feet East of the Northwest corner of the North 1/2 of the Northeast 1/4 of Section 5, Township 35 North, Range 7 West, thence South 1401 feet to the South line of said North 1/2, thence East 219.5 feet, thence North 1401 feet to the North line of said North 1/2, thence West 219.5 feet to the point of beginning in the City of Hobart, Lake County, Indiana. LESS AND EXCEPTING THEREFROM, the South 5.00 feet of the North 25.00 feet thereof taken for road purposes.

Commonly known as: 1551 E. 10th St., Hobart, IN 46342

5. Said premises were formerly owned as joint tenants with rights of survivorship.
6. Affiant represents and warrants to the best of affiant's knowledge there is no estate tax or state inheritance tax and/or funeral expense liability by reason of the death of said decedent.
7. Affiant makes this affidavit to induce the Auditor's Office to transfer title into Affiant's name.

  
Henry Ludwig  
1551 E. 10<sup>th</sup> St.  
Hobart, IN 46342

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.

NOV 08 1999

PETER BENJAMIN  
LAKE COUNTY AUDITOR

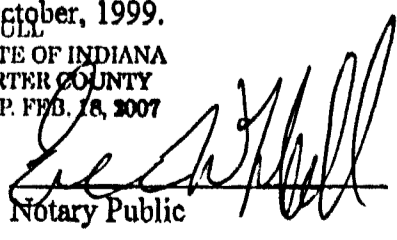
STATE OF INDIANA

COUNTY OF PORTER

BEFORE ME, the undersigned, a Notary Public in and for said County and State, personally appeared Henry Ludwig, and acknowledged the execution of the foregoing instrument and being first duly sworn by me upon his oath, said that the facts alleged under the pains and penalty of perjury are true.

Signed and sealed this 29th day of October, 1999.  
ERIC W. HULL  
NOTARY PUBLIC STATE OF INDIANA  
A RESIDENT OF PORTER COUNTY  
MY COMMISSION EXPIRES: FEB. 18, 2007

FEB 18 2007

  
Notary Public

This instrument prepared by Daniel A. Ecker, Attorney at Law.

HOLD FOR:  
THE TITLE SEARCH CO.

1

000598

#18380

11:02 PM

**INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH**

\* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. **2125-99**

State No. ....

**397921**  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

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

DECEDENT

PARENTS

INFORMANT

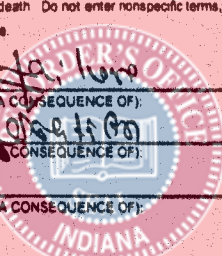
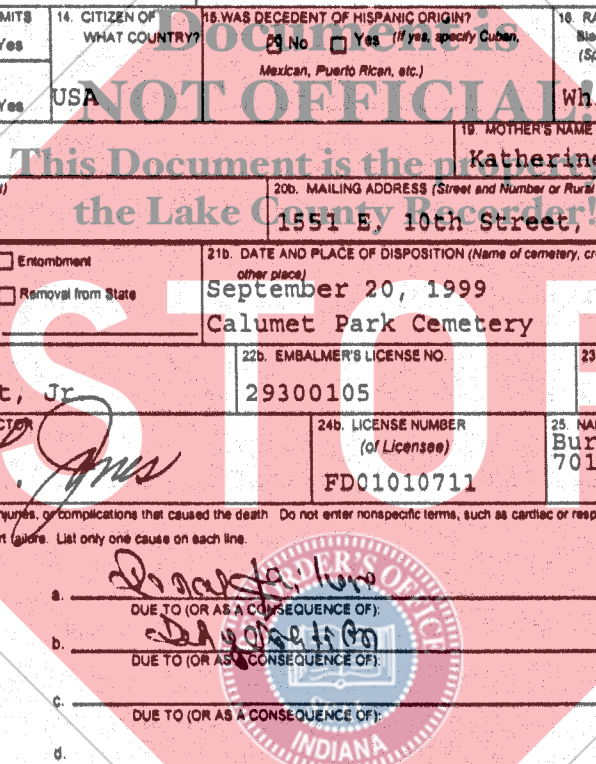
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) <b>Sylvester Ludwig</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>10:10 AM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>September 15, 1999</b>
4. SOCIAL SECURITY NUMBER <b>309-14-9285</b>	5a. AGE - Last Birthday (Years) <b>82</b>	5b. UNDER 1 YEAR Months _____ Days _____	5c. UNDER 1 DAY Hours _____ Minutes _____	6. DATE OF BIRTH (Mo., Day, Yr.) <b>May 02, 1917</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Cedar Lake Indiana</b>		8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? _____		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) <b>Hobart, Indiana</b>		9b. CITY, TOWN, OR LOCATION OF DEATH <b>Hobart</b>	9c. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Widowed</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Custodian</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Hobart City Schools</b>
13a. RESIDENCE - STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>Hobart</b>	13d. STREET AND NUMBER <b>1551 E. 10th Street</b>	
13e. ZIP CODE <b>46342</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	16. RACE - American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>N/A</b>		18. FATHER'S NAME (First, Middle, Last) <b>Louis Ludwig</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Webber</b>			20a. INFORMANT'S NAME (Type/Print) <b>Henry Ludwig</b>	
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1551 E. 10th Street, Hobart, IN 46342</b>		20c. Relationship <b>Son</b>		
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) <b>September 20, 1999 Calumet Park Cemetery</b>		21c. LOCATION - City or Town, State <b>Merrillville, Indiana</b>
22a. EMBALMER'S NAME <b>Russell A. Kraft, Jr.</b>		22b. EMBALMER'S LICENSE NO. <b>29300105</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i> Gordon L. Jones</i>		24b. LICENSE NUMBER (of Licensee) <b>FD01010711</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342</b>	
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. <i>Diagnosis: ICD</i> DUE TO (OR AS A CONSEQUENCE OF):		
b. <i>Septicemia</i> DUE TO (OR AS A CONSEQUENCE OF):		c. _____ DUE TO (OR AS A CONSEQUENCE OF):		
d. _____ DUE TO (OR AS A CONSEQUENCE OF):		INDIANA HEALTH DEPT. <b>SEP 20 1999</b>		
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Complication of preleukemia of hereditary osteoarthritis</i>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) _____		28. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>
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>S. J. Desai</i>		
29c. MEDICAL LICENSE NO. <b>01027933</b>		29d. DATE SIGNED (Month, Day, Year) <b>9-20-99</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20)(Type/Print) <b>Shreyas Desai M.D. 2640 Hamstrom Road, Portage, IN 46368</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams</i>				32. DATE FILED (Month, Day, Year) <b>September 20, 1999</b>
33. MANNER OF DEATH <input checked="" 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		34a. DATE OF INJURY (Month, Day, Year) <b>NOV 08 1999</b>	34b. TIME OF INJURY	34c. INJURY A WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED		34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) <b>PETER BENJAMIN LAKE COUNTY AUDITOR</b>		
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		34g. DATE PRONOUNCED DEAD (Month, Day, Year) <b>September 15, 1999</b>		
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. <b>2</b>		<b>000599</b>		



**FILED**