

2 pages

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2000 002216

2000 JAN 11 PM 12:31

MORRIS W. CARTER  
RECORDER

**AFFIDAVIT OF SURVIVORSHIP**

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Comes now Maxine Hennin, being duly sworn upon her oath and states as follows:

That she is the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot 10, Harding-Meyers Subdivision, in the Town of Lowell, as shown in Plat Book 28, Page 63, in the Office of the Recorder of Lake County, Indiana.

Commonly known as 423 W. Oakley Ave., Lowell, IN 46356  
Key No. 29-04-154-10

That Maxine Hennin and Robert J. Hennin, now deceased, were husband and wife at the time they acquired title as tenants by the entireties, to said real estate by deed of conveyance.

That the marital relationship which existed between this affiant and Robert J. Hennin, husband, continued unbroken from the time they so acquired title to said real estate until the death of Robert J. Hennin, husband, on the 10th day of August, 1998 at which time this affiant acquired title to the real estate as surviving tenant by the entireties.

That the gross value of the estate of the decedent, Robert J. Hennin, as determined for the purposes of Federal Estate Taxes did not require the filing of a Federal Estate Tax Return.

That the real estate described herein was not subject to Indiana Inheritance Tax.

Return to: Centier Bank  
600 E. 84th Ave.  
Merrillville IN 46410

Maxine Hennin  
MAXINE HENNIN

BANKERS TITLE OF NORTHWEST INDIANA, LLC  
9900730NI

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Subscribed and sworn to before me by the affiant this 2nd day of December, 1999.

[Signature]  
Notary Public

My Commission Expires: 10-17-06  
County of Residence: LAKE

**FILED**

JAN 11 2000

This instrument prepared by: Richard E. Anderson, #2408-45  
Anderson & Tauber, P.C.  
9211 Broadway  
Merrillville, Indiana 46410

PETER BENJAMIN  
LAKE COUNTY AUDITOR

00600

11.00  
E.P.

853

\* 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. 265151  
TYPE/PRINT IN PERMANENT BLACK INK

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

1. DECEASED—NAME (First, Middle, Last) <b>Robert J. Hennin</b>		2. SEX <b>Male</b>		3a. TIME OF DEATH <b>03:15P</b>		3b. DATE OF DEATH (Month, Day, Yr) <b>August 10, 1998</b>	
4. SOCIAL SECURITY NUMBER <b>700-18-2558</b>		5a. AGE—Last Birthday (Year) <b>76</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) <b>Feb 25, 1922</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Cedar Lake, IN</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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>St. Anthonys Medical Center</b>				9b. CITY, TOWN, OR LOCATION OF DEATH <b>Crown Point</b>		9c. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Lela Maxine May</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Excavating</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Own Business</b>	
13a. RESIDENCE—STATE <b>IN</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Lowell</b>		13d. STREET AND NUMBER <b>423 W. Oakley</b>	
13e. ZIP CODE <b>46356</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
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>12</b> College (1-4 or 5+)					
18. FATHER'S NAME (First, Middle, Last) <b>George Hennin</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eva Schroeder</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Lela Maxine Hennin</b>				20b. MARITAL ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>423 W. Oakley, Lowell, IN 46356</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" 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>August 14, 1998 Heritage Crematory</b>		21c. LOCATION—City or Town, State <b>Portage, IN</b>			
22a. EMBALMER'S NAME <b>Byron G. Hawkins</b>		22b. EMBALMER'S LICENSE NO. <b>FD29500038</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Mally E. Hawkins</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO9200061</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Sheets Funeral Home, FH83004277 604 E. Commercial Ave. Lowell, IN</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. <b>Sepsis</b>							
b. <b>hypotensive - abdominal</b>							
c. <b>dementia</b>							
d. _____							
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) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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. <b>5000 2521</b>		29d. DATE SIGNED (Month, Day, Year) <b>08-11-98</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Randall Hile MD, 1020 E. Commercial Ave., Lowell, IN 46356</b>							
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>							
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		33a. DATE OF INJURY (Month, Day, Year)		33b. TIME OF INJURY		33c. INJURY AT WORK? (Yes or no) <b>JAN 1 1 2000</b>	
33d. DATE DEATH OCCURRED		34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)					
34b. DATE OF DEATH		34c. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>AUG 10 1998</b>					
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, bicyclist, or other. <b>PETER BENJAMIN LAKE COUNTY AUDITOR LAKE COUNTY HEALTH COMMISSIONER</b>					

DECEDENT

PARENTS

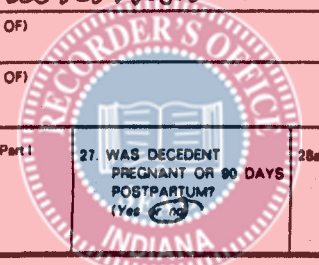
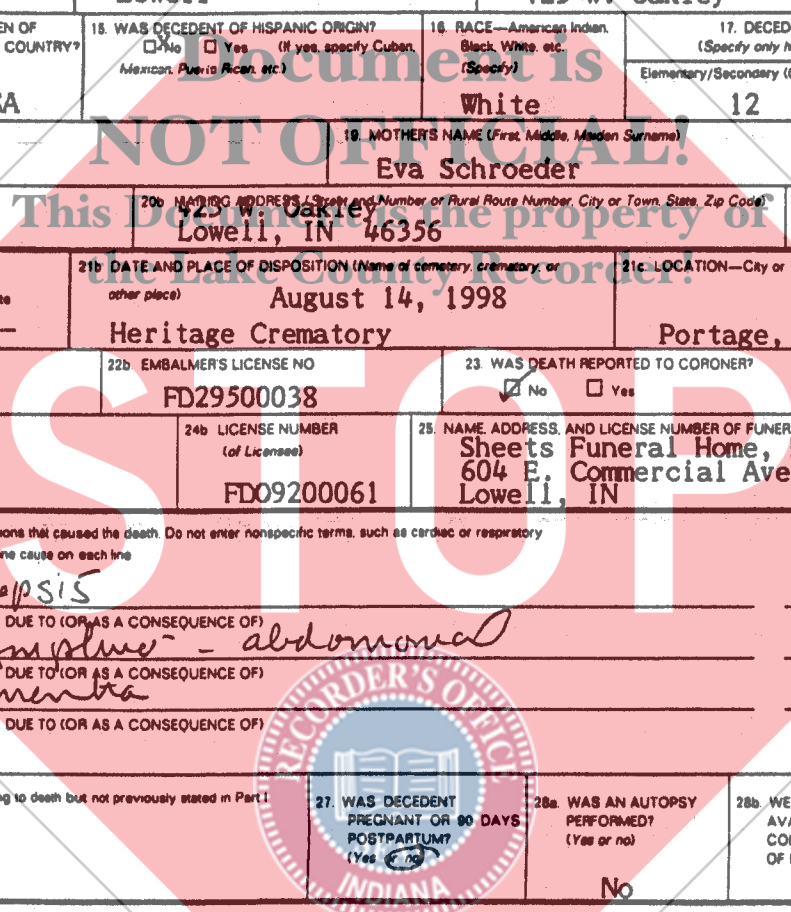
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



**FILED** AUG 13 1998

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