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STATE OF INDIANA
COUNTY OF LAKE

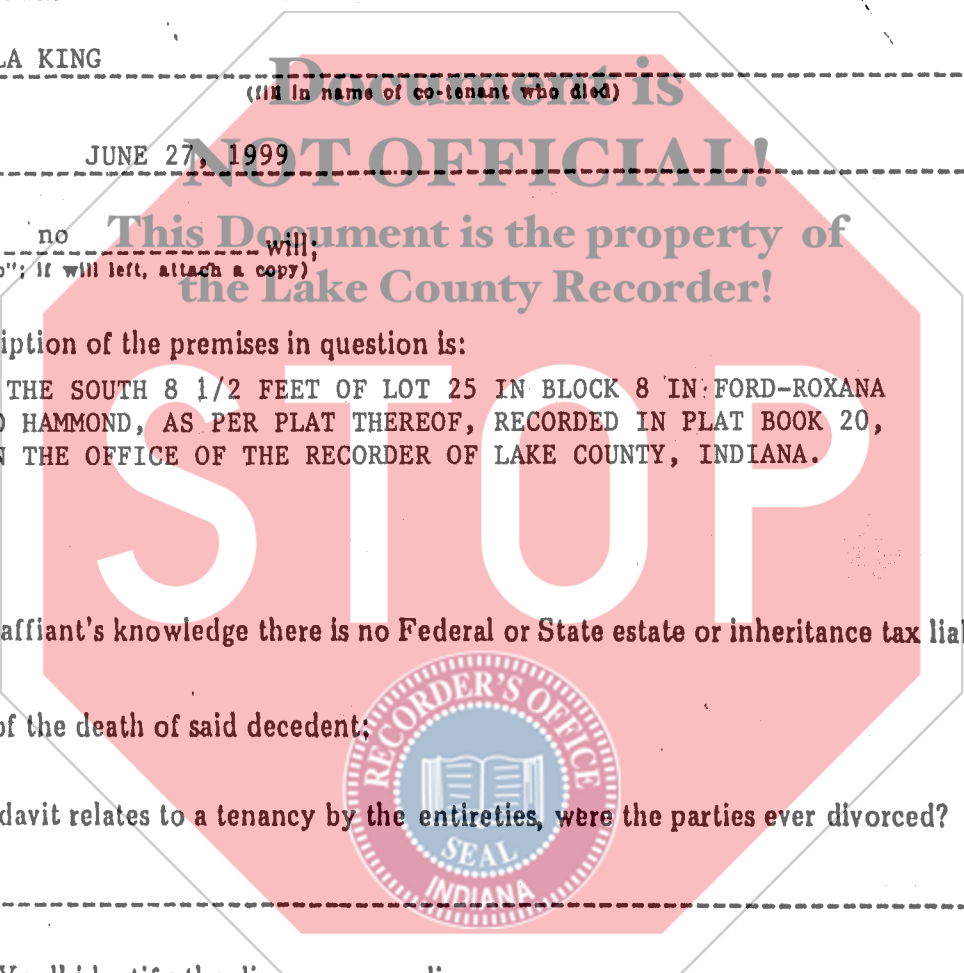
S. S.

NOTARIAL CARTER

On this MARCH 3, 2000 before me personally appeared ABEL H. KING
(insert date)

to me personally known, who being duly sworn on oath did say that:

- Affiant resides at the address given below affiant's signature;
- Affiant is owner
(state interest of affiant in the above premises as "owner," "son of owner," etc.)
- Said premises were formerly owned as joint tenants or as tenants by the entireties by
ABEL H. KING and DELLA KING;
- Said DELLA KING
(fill in name of co-tenant who died)
died on JUNE 27, 1999
leaving no will;
(insert "a" or "no"; if will left, attach a copy)
- The legal description of the premises in question is:
LOT 24 AND THE SOUTH 8 1/2 FEET OF LOT 25 IN BLOCK 8 IN FORD-ROXANA
ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 20,
PAGE 23, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
- To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent;
- Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?
no
(If answer is "Yes," identify the divorce proceedings: _____)
- Affiant's relationship to the deceased was husband



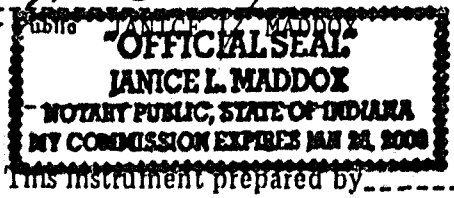
Signature: Abel H. King
ABEL H. KING

Address: 2045 Porte De Leau, Highland, IN

Subscribed and sworn to before me by the affiant

this MARCH 3, 2000
(insert date)

Janice L. Maddox
Notary Public



My Commission Expires

1074

This instrument prepared by _____

FILED

MAR 09 2000

PETER BENJAMIN 8850
LAKE COUNTY AUDITOR

ABEL H. KING

12:00 P.M.
CK# 200578

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 576

CERTIFICATE OF DEATH

June 29, 1999
Date issued
Franklin J. Premuda, M.D.
Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Della D. King		2 SEX Female		3a TIME OF DEATH 5:09P.M.		3b DATE OF DEATH (Month Day Yr) June 27, 1999	
4 *SOCIAL SECURITY NUMBER 411-50-4329		5a AGE—Last Birthday (Years) 63		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6a WAS DECEDENT A US VETERAN? No		6b YEAR LAST SERVED IN US ARMED FORCES? N/A		8 DATE OF BIRTH (Mo Day Yr) Jul. 24, 1935			
7 BIRTHPLACE (City and State or Foreign Country) Campbell County, Tenn.							
9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence							
9b FACILITY NAME (If not institution, give street and number) Saint Margaret Mercy Healthcare (North)				9c CITY TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Abel King		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Home Maker		12b KIND OF BUSINESS/INDUSTRY Own Home	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY TOWN OR LOCATION Hammond		13d STREET AND NUMBER 7424 Oakdale Ave.	
13e ZIP CODE 46324		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	
16 FATHER'S NAME (First Middle Last) Andrew Brock		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 8					
18 MOTHER'S NAME (First Middle Maiden Surname) Maudie (unavailable)				19 RACE—American Indian Black White etc (Specify) White			
20a INFORMANT'S NAME (Type/Print) Abel King				20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 7424 Oakdale Ave., Hammond, Ind., 46324		20c Relationship Husband	
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) July 1, 1999 Chapel Lawn Cemetery			21c LOCATION—City or Town State Scherverville, Indiana		
22a EMBALMERS NAME David R. Peterson		22b EMBALMERS LICENSE NO FDO 8601585		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>D. Kuiper</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home, 9039 Kleinman Rd Highland, Indiana 46322 FH 83007500			
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. MULTI-ORGAN SYSTEM FAILURE DUE TO (OR AS A CONSEQUENCE OF)							
b. STAPH AUREUS SEPSIS DUE TO (OR AS A CONSEQUENCE OF)							
c. CELLULITIS DUE TO (OR AS A CONSEQUENCE OF)							
d. 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 CONGESTIVE HEART FAILURE ACUTE NEUROLOGICAL EVENT DIABETES MELLITUS II SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE							
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) 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>Mal [Signature]</i>				29c MEDICAL LICENSE NO 1036785		29d DATE SIGNED (Month Day Year) June 28, 1999	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) M. Kevin, M.D. 7905 Calumet Ave. Munster, Indiana 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Premuda M.D.</i>						32 DATE FILED (Month Day Year) June 29, 1999	
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		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) MAR 09 2000			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify					
PETER BENJAMIN LAKE COUNTY AUDITOR 00861							