

STATE OF INDIANA)
)SS
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED

2000-022163
SURVIVORSHIP AFFIDAVIT 63

2000 MAR 21 PM 12:36

Dale Roy Shepherd, being duly sworn, deposes and says:

1. That prior to 8/17/99, your affiant and ~~his~~ husband (his wife), Geneva P. Shepherd, were the owners as tenants by the entireties of the following described real estate in Lake County, Indiana, to-wit:

Lot 1, except the South 50 feet thereof, in Block 2 in Sela A. Smith's First Addition to Hobart, as per plat thereof, recorded in Plat Book 12, page 23, in the Office of the Recorder of Lake County, Indiana.

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307
00-01358

FILED

Document is
NOT OFFICIAL

MAR 20 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

This Document is the property of
the Lake County Recorder!

2. That the marital relationship which existed between your affiant and ~~his~~ husband (his wife), Geneva P. Shepherd, continued unbroken from the time they so acquired title to said real estate until the death of said Geneva P. Shepherd, a resident of Lake County, Indiana, on 8/17/99, at which time this affiant acquired title to said real estate as surviving tenant by the entireties.

3. That the record of death of said Geneva P. Shepherd, is duly entered in local record no. 189599 maintained by the Lake Cty. Health Department.

4. That to the best of affiant's knowledge, there are no Federal Estate or Indiana Inheritance Taxes due or payable by reason of the death of said decedent.

5. That your affiant makes this affidavit for the purpose of establishing the foregoing facts and to induce the Lake County Auditor to reflect on his records that your affiant is now the sole owner of the above described real estate.

IN WITNESS WHEREOF, your affiant has executed this affidavit, this 13th day of March, 2000, ~~18~~.

Dale Roy Shepherd
DALE ROY SHEPHERD

Subscribed and sworn to before me, a Notary Public, this 13th day of March, 2000, ~~18~~.

Ervin C. Carstensen
Notary Public, Lake County Resident
Ervin C. Carstensen

My Commission Expires:

7/01/01

This Instrument Prepared By: ERVIN C. CARSTENSEN, I. D. #3141-45
Attorney at Law
503 Main St., Hobart, IN 46342

00463

Ly
1200
2/21

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

INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

State No.....

Local No. 14015-111

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 18-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First Middle Last) GENEVA P. SHEPHERD		2. SEX Female	3a. TIME OF DEATH 10:05AM	3b. DATE OF DEATH (Month Day Yr) August 17, 1999	
4. SOCIAL SECURITY NUMBER 415-40-2246	5a. AGE - Last Birthday (Years) 71	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) August 18, 1927	
7. BIRTHPLACE (City and State or Foreign Country) Cleveland, Tennessee	8a. WAS DECEDENT A U.S. VETERAN? No				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A		8c. 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			
9b. FACILITY NAME (if not institution, give street and number) St. Mary Medical Center		9c. CITY TOWN OR LOCATION OF DEATH Hobart	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (if wife, give maiden name) Dale Shepherd	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 Home	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 3502 Kosciusko Street		
13e. ZIP CODE 46342	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 8 College (1-4 or 5+)		13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
18. FATHER'S NAME (First, Middle, Last) James O'Neil		19. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Hill			
20a. INFORMANT'S NAME (Type/Print) Dale Shepherd		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Kosciusko, Hobart, IN 46342		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) August 20, 1999 Evergreen Memorial Park		21c. LOCATION - City or Town, State Hobart, Indiana 2000	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FDO1006463	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME PETER BENJAMIN LAKE COUNTY AUDITOR Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342		
26. PART I - Enter the disease, 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>Carcinoma of lung.</i> DUE TO (OR AS A CONSEQUENCE OF)			
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b. _____ DUE TO (OR AS A CONSEQUENCE OF)			
		c. _____ DUE TO (OR AS A CONSEQUENCE OF)			
		d. _____			
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I					
<i>pneumonia</i>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	28a. WAS AN AUTOPSY PERFORMED? (Yes or no) COUNTY HEALTH No	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
<i>congestive heart failure</i>					
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>John O. Carter MD</i>		29c. MEDICAL LICENSE NO. 01017684	29d. DATE SIGNED (Month Day Year) 8/18/99		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John O. Carter MD, 295 S. Wisconsin Street, Hobart, IN 46342					
HEALTH OFFICER'S SIGNATURE <i>Alexander Stikina MD</i>					
32. DATE FILED (Month Day Year) <i>August 19, 1999</i>					
33. MANNER OF DEATH <input 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)	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.			

00464