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FILED
2000 JUN 29 AM 10:46
MORRIS W. GENTLER
RECORDER

2000 046027

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SURVIVORSHIP AFFIDAVIT

Comes now Joan J. Turner, who, being first duly sworn, deposes and states as follows:

1. Your affiant resides at 572 Ravine Drive, Valparaiso, Indiana 46385.
2. Affiant is the owner in fee simple of real estate located in Lake County, Indiana ("Real Estate").
3. The legal description of the Real Estate is as follows:

The North 690.00 feet of the Southeast 1/4 of the Northwest 1/4 of Section 21, Township 35 North, Range 8 West of the Second Principal Meridian, in Lake County, Indiana, excepting therefrom the East 1017.54 feet, the West 126 feet, and the South 40 feet of the West 106 feet thereof.
4. The Real Estate was formerly owned by your Affiant and Affiant's spouse, Patrick J. Turner, as tenants by the entireties.
5. Patrick J. Turner, the Affiant's spouse, died on August 30, 1997. A certified copy of the death certificate is attached.
6. Your Affiant and Patrick J. Turner were married, and they lived continuously together as husband and wife until the death of Patrick J. Turner.

Further Affiant Sayeth Not.

Joan J. Turner

JOAN J. TURNER

FILED

2000

F 30139 1 OF 4

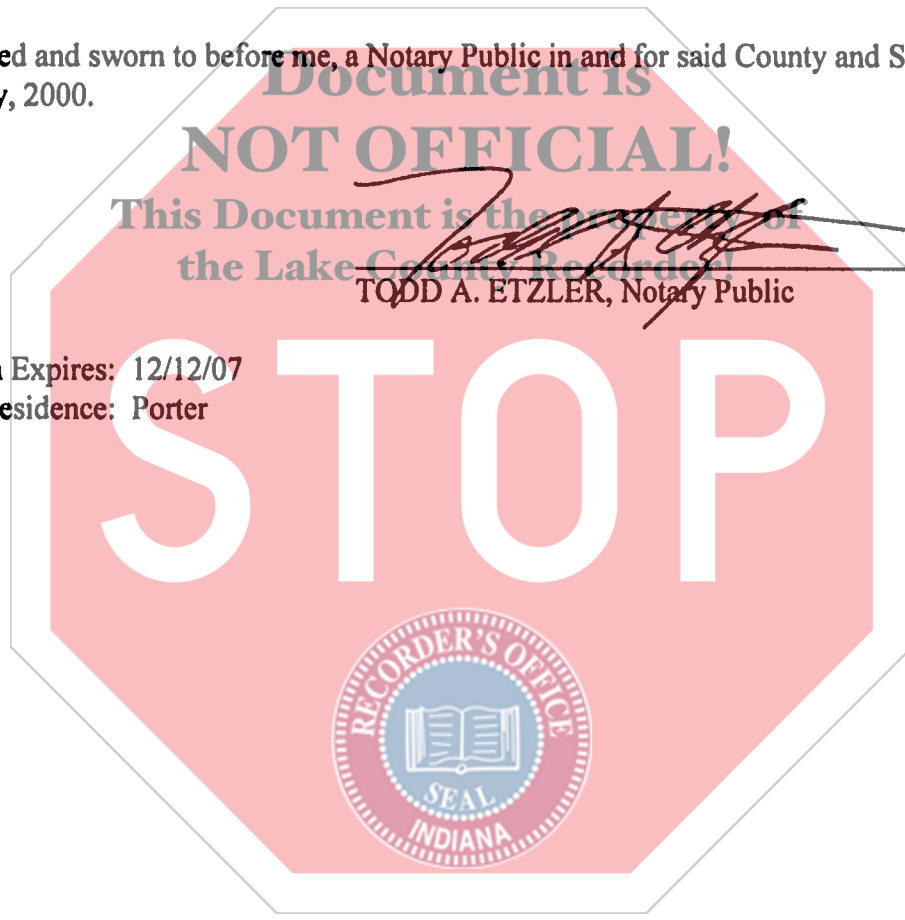
HOLD FOR FIRST AMERICAN TITLE

**PETER BENJAMIN
LAKE COUNTY AUDITOR**

02300
1300
EP
TA

STATE OF INDIANA)
)SS
COUNTY OF LAKE)

Subscribed and sworn to before me, a Notary Public in and for said County and State this
3rd day of May, 2000.



My Commission Expires: 12/12/07
My County of Residence: Porter

This instrument prepared by Todd A. Etzler, Attorney at Law, 15 N. Franklin Street, Suite 200,
Valparaiso, Indiana 46383

This Document Not Valid Unless
Stamped on Reverse Side and
Embossed With Raised Seal of
Porter County

PORTER COUNTY
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1 DECEASED—NAME (First, Middle, Last) PATRICK J. TURNER		2 SEX Male	3a TIME OF DEATH 7:00 P.M.	3b DATE OF DEATH (Month, Day, Yr.) August 30, 1997
4 SOCIAL SECURITY NUMBER 104-20-9667	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.) March 27, 1926
7 BIRTHPLACE (City and State or Foreign Country) New York, New York	8a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8b WAS DECEDENT A U.S. VETERAN? Yes	8c YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9a FACILITY NAME (If not institution, give street and number) Porter Memorial Hospital		
9b CITY, TOWN OR LOCATION OF DEATH Valparaiso		9c COUNTY OF DEATH Porter		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Joan Parise	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Operator/Owner	12b KIND OF BUSINESS/INDUSTRY Pacesetter Beauty Sup.	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 1086 W. 81st. Avenue	
13e ZIP CODE 46410	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 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) 12 College (11-4 or 5+)		18 FATHER'S NAME (First, Middle, Last) James Gibbons		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Purtell		20a INFORMANT'S NAME (Type/Print) Joan Turner		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1086 W. 81st. Ave., Merrillville, IN 46410		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) September 3, 1997 Holy Sepulchre Cemetery		21c LOCATION—City or Town, State Worth, Illinois
22a EMBALMER'S NAME Gordon L. Jones		22b EMBALMER'S LICENSE NO. 1010711		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Perennial P. Burns</i>		24b LICENSE NUMBER (of Licensee) 1013890		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002445 10101 Bdwy., Crown Point, IN 46307
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
a IMMEDIATE CAUSE (Final disease or condition resulting in death) Myocardial Infarction				2 days
b DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Arteriosclerosis				Years
c DUE TO (OR AS A CONSEQUENCE OF)				
d DUE TO (OR AS A CONSEQUENCE OF)				
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) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) Yes		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes
29a CERTIFIER (Check only one) <input 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 checked="" 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>Paul A. Evans</i> Coroner of Porter County, Indiana		29c MEDICAL LICENSE NO. 11115D		29d DATE SIGNED (Month, Day, Year) Sept. 2, 1997
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) John A. Evans 517 Broadway Chesterton, IN 46304				
31 HEALTH OFFICER'S SIGNATURE <i>Gary A. Babcock</i>			32 DATE FILED (Month, Day, Year) September 5, 1997	
33 MANNER OF DEATH <input checked="" 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) Aug. 30, 1997	34b TIME OF INJURY 6:30 P.M.	34c INJURY AT WORK? (Yes or no) No
34d DESCRIBE HOW INJURY OCCURRED PETERSON/ADP LAKE COUNTY HEALTH DEPARTMENT back at Home, taken to Department.		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Residence		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State) 1086 West 81st. Avenue Merrillville, Indiana				
34g DATE PRONOUNCED DEAD (Month, Day, Year) August 30, 1997		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. No		