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2002 068137

2002 JUL 10 PM 2:04

RECORDER

Record & Return to: Robert L. Meinzer, Jr., P. O. Box 111, St. John, IN 46373

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

JEANETTE RUTH WELCH, being first duly sworn upon her oath, deposes and says:

1. That I am the owner of the following described real estate:

Lot 4, Block 3, Oak Heights Addition, as shown in Plat Book 27, page 86, Office of the Recorder, Lake County, Indiana.

2. That I own said real estate subject to a life estate of Mildred Larkin.

3. That Mildred Larkin died on April 30, 2002; that a copy of her Death Certificate is attached hereto, made a part of this Affidavit, and marked as Exhibit A.

4. That the purpose of this Affidavit is to show that the life estate has now been extinquished and that the undersigned holds said property in fee simple.

I affirm under the penalties of perjury, that the aforesaid representations are true.

Jeanette Ruth Welch
JEANETTE RUTH WELCH

SUBSCRIBED AND SWORN to before me, a Notary Public, this 22 day of July, 2002.

My Commission Expires
July 18, 2009
Resident of Lake County

ROBERT L. MEINZER, JR.
NOTARY PUBLIC

This Instrument Prepared by:
ROBERT L. MEINZER, JR. #9132-45, Attorney at Law
9190 Wicker Avenue, P. O. Box 111, St. John, IN 46373-111
Tel: (219) 365-4321; fax 219-365-9510

FILED

JUL 26 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

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11.00
M.V.
22388
lower

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

Local No. 1043-02

816113

(10)

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED - NAME (First, Middle, Last): Mildred Larkin
2. SEX: Female
3a. TIME OF DEATH: 4:55 PM
3b. DATE OF DEATH (Month, Day, Yr.): April 30, 2002
4. SOCIAL SECURITY NUMBER: 430-20-5476
5a. AGE - Last Birthday (Years): 78
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): January28,1924
7. BIRTHPLACE (City and State or Foreign Country): Harrison Arkansas
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
PLACE OF DEATH (Check only one See instructions): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 10528 Baker St.
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): N/A
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: Own Home
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Crown Point
13d. STREET AND NUMBER: 10528 Baker St.
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☒ No ☐ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 10; College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last): Dave Randall
19. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Wolfe

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Jeanette Welch
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12051 Lewis St., St. John, IN 46373
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 3, 2002 Chapel Lawn Memorial Gardens
21c. LOCATION - City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Casmir R. Pulaski
22b. EMBALMER'S LICENSE NO.: FD08900012
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD09000013
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home FH19900060 109 N. East St.,Crown Point,Indiana

CAUSE OF DEATH

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. DUE TO (OR AS A CONSEQUENCE OF): Cardiac sclerotic heart disease
b. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic cerebral vascular disease
c. DUE TO (OR AS A CONSEQUENCE OF): Generalized arteriosclerosis
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: Chronic obstructive lung disease Hypertension
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

CERTIFIER

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: [signature]
29c. MEDICAL LICENSE NO.: IN25043
29d. DATE SIGNED (Month, Day, Year): 5/3/2002

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Krishnan Potti MD 8300 Broadway, Merrillville, IN 46410
31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): MAY 3, 2002

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year):
34b. [illegible]
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): JUL 26 2002
34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.

FILED
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
MAY 03 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR
"EXHIBIT A"

001829