



SURVIVORSHIP AFFIDAVIT

3

STATE OF INDIANA
COUNTY OF LAKE

S. S.

2002 10 4 9 0

On this November 6, 2002 before me personally appeared ROBERT S

(insert date)

KUIPER

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

1. Affiant resides at the address given below affiant's signature;

2. Affiant is Owner (state interest of affiant in the above premises as "owner," "son of owner," etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by ROBERT S. KUIPER and JEANETTE F. KUIPER

4. Said JEANETTE F. KUIPER (fill in name of co-tenant who died)

died on May 1, 2000

leaving no will; (insert "a" or "no"; if will left, attach a copy)

5. The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of \$600,000.00 and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of said decedent;

6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NO

(If answer is "Yes," identify the divorce proceedings:)

7. Affiant's relationship to the deceased was Husband

Legal description attached.

Signature: Robert S. Kuiper

Address: 254 South Fremont, Lowell, IN

Subscribed and sworn to before me by the affiant

this November 6, 2002 (insert date)

Penny Bizoukas Notary Public

My Commission Expires 2/7/08

This instrument prepared by William Theodoros

Theodoros & Routh, P.C., 8750 Broadway, Ste. A Merrillville, In. 46410

FILED

NOV 10 2002

PETER BENJAMIN LAKE COUNTY AUDITOR

001202

14.00 LP

ck

11389

That Affiant is the owner in fee simple of the following described real estate, located in Lake County, State of Indiana, described as follows, to wit:

Part of the Northwest Quarter of the Northeast Quarter of Section 26, Township 33 North, Range 9 West of the 2<sup>nd</sup> P.M., including that part of Lot Ten (10) of Clark's Addition to the Town of Lowell, Indiana, and that part of Lot Twenty-Six (26), of Union Addition to the Town of Lowell, Indiana, lying within the boundary of the following description: Commencing at a point 98.5 feet South of the intersection of the East line of Fremont Street with the North line of said Section; thence East a distance of 235 feet; thence South 98.5 feet to the center of the Old channel of Cedar Creek; thence West 235 feet, to the East line of Fremont Street; thence North 98.5 feet to the point of beginning, in Lake County, Indiana. Key No. 4-13-12.



\* 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. 1041-00

765798

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Jeanette F. Kuiper				2 SEX Female		3a TIME OF DEATH 10:34A M		3b DATE OF DEATH (Month, Day, Yr) May 1, 2000		
4 *SOCIAL SECURITY NUMBER 309-30-2891		5a AGE—Last Birthday (Years) 69		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) Apr. 22, 1931		7 BIRTHPLACE (City and State or Foreign Country) Lowell, Indiana
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a PLACE OF DEATH (Check only one. See instructions) 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 checked="" type="checkbox"/> Residence						
9b FACILITY NAME (If not institution, give street and number) 254 South Fremont Street				9c CITY, TOWN OR LOCATION OF DEATH Lowell			9d COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Robert S. Kuiper		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 Lowell			13d STREET AND NUMBER 254 South Fremont			
13a ZIP CODE 46356		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) College (1-4 or 5+) 2
18 FATHER'S NAME (First, Middle, Last) Clayton Randolph						19 MOTHER'S NAME (First, Middle, Maiden Surname) Alice Love				
20a INFORMANT'S NAME (Type/Print) Robert S. Kuiper				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 254 South Fremont St., Lowell, Ind. 46356				20c Relationship Husband		
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) May 4, 2000 Lowell Cemetery				21c LOCATION—City or Town, State Lowell, Indiana			
22a EMBALMER'S NAME Edgar C. Gleim			22b EMBALMER'S LICENSE NO. FDO 1016173			23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR <i>C.H. 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 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Esophageal carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>metastatic adenocarcinoma</i> DUE TO (OR AS A CONSEQUENCE OF) c. <i>liver failure from metastatic cancer</i> DUE TO (OR AS A CONSEQUENCE OF) d. _____ Approximate Interval Between Onset and Death										
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/>						28a WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/>		
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>Randall L. Hile</i>						29c MEDICAL LICENSE NO. 50002521		29d DATE SIGNED (Month, Day, Year) 5/2/2000		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Randall L. Hile MD 1020 E Commercial Lowell, IN 46356										
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Hillman</i> MD										
32 DATE FILED (Month, Day, Year) MAY 2, 2000		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 PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)				
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <i>Alexander S. Hillman</i> MD LAKE COUNTY HEALTH COMMISSIONER								