Please Return To: ATTORNEY ARNOLD KREVITZ
500 East 86th Avenue, Merrillville, IN 46410

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS: 2002 104944
COUNTY OF LAKE)

2002 NOV 15 11:12

RECORDER

GEORGE N. WILSON, being first duly sworn upon his oath, deposes and says:

1. That he was married to DARLENE WILSON, who died a resident of Hobart, Lake County, Indiana, on July 31, 2002.

2. That at the time of her death, DARLENE WILSON and GEORGE N. WILSON, Husband and Wife, held title under a Quit-Claim Deed to the following-described Real Estate, to-wit:

Lot 1 in Wildwood on the Lake, in the City of Hobart, as per plat thereof, recorded in Plat Book 31, page 44, in the Office of the Recorder of Lake County, Indiana.
Commonly known as: 307 South Virginia Street, Hobart, IN 46342
Key No. 18-261-1
Tax Unit 27

Commonly known as: 307 S. Virginia Street, Hobart, Indiana 46342
Key Number: 18-261-1
Unit 27

3. That the Affiant and the Decedent, DARLENE WILSON, were Husband and Wife continuously from the time they acquired title to the above-described Real Estate to the time of her death on July 31, 2002.

4. That the Estate of decedent, DARLENE WILSON, was not of sufficient value to be subject to Federal Estate Taxes or Indiana Inheritance Taxes.

FURTHER AFFIANT SAYETH NOT.

FILED
NOV 15 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

GEORGE N. WILSON

Subscribed and sworn to before me, a Notary Public, this 13th day of November, 2002.

Arnold Krevitz, Notary Public
Resident of Lake County

My Commission Expires:
02/24/09

This Instrument Prepared by: ARNOLD KREVITZ, Attorney At Law
500 East 86th Av., Merrillville, IN 46410

12 N.H. 21744

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occ's

* **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.

Local No. 1291-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Entry
1. DECEASED—NAME (First, Middle, Last)	DARLENE WILSON
2. SEX	Female
3a. TIME OF DEATH	2:55 PM
3b. DATE OF DEATH (Month, Day, Yr)	July 31, 2002
4. *SOCIAL SECURITY NUMBER	343-26-3877
5a. AGE—Last Birthday (Years)	68
5b. UNDER 1 YEAR (Months / Days)	
5c. UNDER 1 DAY (Hours / Minutes)	
6. DATE OF BIRTH (Mo, Day, Yr)	September 21, 1933
7. BIRTHPLACE (City and State or Foreign Country)	Chicago Illinois
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
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)	George Wilson
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	Secretary
12b. KIND OF BUSINESS/INDUSTRY	Electricial
13a. RESIDENCE—STATE	Indiana
13b. COUNTY	Lake
13c. CITY, TOWN, OR LOCATION	Hobart
13d. STREET AND NUMBER	307 S. Virginia Street
13e. ZIP CODE	46342
13f. INSIDE CITY LIMITS	[ ] No [X] Yes
13g. ON A FARM?	[X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?	U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	[X] No [ ] Yes
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+)	12

PARENTS

Field	Entry
18. FATHER'S NAME (First, Middle, Last)	Leo Hall
19. MOTHER'S NAME (First, Middle, Maiden Surname)	Florence (Unavailable)

INFORMANT

Field	Entry
20a. INFORMANT'S NAME (Type/Print)	George Wilson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	307 S. Virginia Street, Hobart, IN 46342
20c. Relationship	Husband

DISPOSITION

Field	Entry
21a. METHOD OF DISPOSITION	[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	Aug 5, 2002 Evergreen Memorial Park
21c. LOCATION—City or Town, State	Hobart IN
22a. EMBALMER'S NAME	James J. Krause
22b. EMBALMER'S LICENSE NO.	FD01006463
23. WAS DEATH REPORTED TO CORONER?	[X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR	James J. Krause (signature)
24b. LICENSE NUMBER (of Licensee)	FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME	Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Coronary Artery Disease	
b. DUE TO (OR AS A CONSEQUENCE OF)	Congestive Cardiomyopathy	
c. DUE TO (OR AS A CONSEQUENCE OF)	CHF	
d. DUE TO (OR AS A CONSEQUENCE OF)		

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

Field	Entry
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)

- [X] 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.

Field	Entry
29b. SIGNATURE AND TITLE OF CERTIFIER	Mark O. Carter (signature)
29c. MEDICAL LICENSE	01036415
29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	Mark O. Carter MD 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

Field	Entry
31. HEALTH OFFICER'S SIGNATURE	(signature)
32. DATE FILED (Month, Day, Year)	Aug 5, 2002
33. MANNER OF DEATH	[X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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.	

FILED

NOV 15 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

001255

SDH06-004 State Form 10110 (R5/1-99)