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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2002 NOV 20 AM 9:48

MORRIS W. CARTER
RECORDER

2002 106131

Chicago Title Insurance Company

Chicago Title Insurance Company

620029263

SURVIVORSHIP AFFIDAVIT

On this 23rd of OCTOBER, 2002 before me personally appeared
(insert date)

ROBERT TRULLEY

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 SON OF 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 PAUL F. TRULLEY and LOIS MARIE TRULLEY;
4. Said PAUL F. TRULLEY
   (fill in name of co-tenant who died)
   died on JUNE 22, 2000
   leaving WILL will;
   (insert "a" or "no"; if will left, attach a copy)
5. The legal description of the premises in question is:

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RECORDER'S OFFICE SEAL INDIANA

6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☒ No

If yes, then estimated taxes due are $_____.

The taxes due are ☐ paid or ☐ unpaid.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
NOV 19 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

FILED
NOV 19 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

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

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

);

8. Affiant's relationship to the deceased was SON

Signature: Robert C. Trulley

Printed Name: Robert C. Trulley

Address: 9082 Knickerbocker St.

St. John, IN 46373

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Subscribed and sworn to before me by the affiant

this October 23, 2002
(insert date)

Renée N. Trulley
Notary Public

Printed Name RENÉ N. TRULLEY

My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires 8-18-02

This instrument prepared by ROBERT C. TRULLEY

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

(10)

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1477-00
393007

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)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Paul	F.	Trulley	Male	5:25am	June 22, 2000

4. *SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months	Days	5c. UNDER 1 DAY Hours	Minutes	6. DATE OF BIRTH (Mo., Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
312-05-4787	84					August22,1915	Rensselear Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	PLACE OF DEATH (Check only one See instructions)
No	N/A	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Methodist Hospital Southlake Campus	Merrillville	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)	12b. KIND OF BUSINESS/INDUSTRY
Married	Lois Funk	Pit Craneman	U.S. Steel

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Crown Point	315 Hoffman St.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE — American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46307	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph Trulley	Emma Mary Feldhaus

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Lois Trulley	315 Hoffman St., Crown Point, IN 46307	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION - City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	June 24, 2000 St. Mary Cemetery	Crown Point, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Raymond E. White Jr.	FD08700086	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Michelle Tracy	FD29700007	Geisen Funeral Home FH19900060 109 N. East St., Crown Point, Indiana

CAUSE OF DEATH

X 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 prior to cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute myeloid Leukemia	20 hrs
	DUE TO (OR AS A CONSEQUENCE OF): Renal Failure	24 hrs.
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last. JUN 26 2000	DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	

Alexander E. Williams, MD

CERTIFIED TRUE COPY OF THE RECORD ON FILE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
LAKE COUNTY HEALTH COMMISSIONER

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
Dehydration, Hypernatremia		No	No

CERTIFIER

X 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) as stated.

X 29b. SIGNATURE AND TITLE OF CERTIFIER	X 29c. MEDICAL LICENSE NO.	X 29d. DATE SIGNED (Month, Day, Year)
Raphael E. Albertus	01030144	6/23/00

X 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
251 West 84th Dr. Merrillville, IN. / 46410 R.E. - ALBERTUS

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
Alexander E. Williams, MD

32. DATE FILED (Month, Day, Year) June 26, 2000

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

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