SURVIVORSHIP AFFIDAVIT

STATE OF OREGON)

) SS:

COUNTY OF Lane)

2003 115930

On this 23rd Sept. 2003 before me personally appeared Laura Gillpatrick

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 the daughter of the owner of said real estate located at 1910 Forsythe Square, Whiting, IN 46394
(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 Marjeanne Cuklin
4. Said Marjeanne Cuklin
(fill In name of co-tenant who died)
died on May 1, 2002
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 $500,000 and to the best of affiant's knowledge all estate or inheritance tax liability by reason of the death of said decedent have been paid and the Indiana Inheritance Tax Return was filed on January 23, 2003;
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:);

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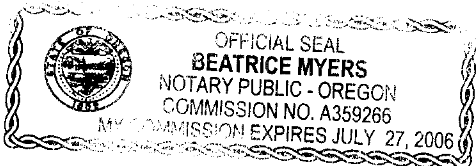
RECORDER'S OFFICE SEAL



Signature: Laura Gillpatrick

Address: Laura Gillpatrick
2350 N. Terry, #75
Eugene, OR 97402

Subscribed and sworn to before me by the affiant this 23rd September 2003
(Insert date)

Beatrice M. Myers
Notary Public and
Resident of Lane County, Oregon

My Commission Expires 27 July 2006

This instrument prepared by Joni M. Ritzi, Attorney #16182-45 of Danko, Goldsmith & Ritzi
Lake County, Indiana

12.00

Ck# 4408
CP

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. 113

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

1 DECEASED—NAME (First Middle Last): MARJEANNE CUKLIN

2 SEX: Female

3a TIME OF DEATH: 8:50 A M

3b DATE OF DEATH (Month Day Yr): May 1, 2002

4 *SOCIAL SECURITY NUMBER: 310-38-6526

5a AGE—Last Birthday (Years): 62

5b UNDER 1 YEAR: Months / Days

5c UNDER 1 DAY: Hours / Minutes

6 DATE OF BIRTH (Mo Day Yr): June 21, 1939

7 BIRTHPLACE (City and State or Foreign Country): Whiting, IN

8a WAS DECEDENT A U S VETERAN?: No

8b YEAR LAST SERVED IN US ARMED FORCES?: N/A

9a 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): St. Catherine Hospital

9c CITY TOWN OR LOCATION OF DEATH: East Chicago

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): Legal Secretary

12b KIND OF BUSINESS/INDUSTRY: Legal

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Hammond (P.O. Whiting)

13d STREET AND NUMBER: 1910 Forsythe Square

13e ZIP CODE: 46394

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): ; College (1-4 or 5 +): 4

PARENTS

18 FATHER'S NAME (First Middle Last): Joseph Lattak

19 MOTHER'S NAME (First Middle Maiden Surname): Mary Patka

INFORMANT

20a INFORMANT'S NAME (Type/Print): Laura Gillpatrick

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code): 2350 N. Terry #75 Eugene, Oregon 97402

20c Relationship: Daughter

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place): May 4, 2002 Regional Cremation Services

21c LOCATION—City or Town State: Munster, IN

22a EMBALMER'S NAME: THOS. OWENS

22b EMBALMER'S LICENSE NO: FDE 1001049

23 WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR:

24b LICENSE NUMBER (of Licensee): FDE 1001049

25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Owens Funeral Home FDH 3007291 816-119th St., Whiting, IN 46394

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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

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a METASTATIC BREAST CANCER — Approximate Interval Between Onset and Death: [handwritten, illegible]

DUE TO (OR AS A CONSEQUENCE OF)

b

DUE TO (OR AS A CONSEQUENCE OF)

c

DUE TO (OR AS A CONSEQUENCE OF)

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

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): N/A

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) ... ☐ HEALTH OFFICER On the basis of examination and/or investigation in my opinion death occurred at the time date ... ☐ 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: 01[illegible]

29d DATE SIGNED (Month Day Year): 5-6-02

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): LYLE R. MUNN MD 4321 FIR ST [illegible] 46312

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Dr Timothy Raykovich

32 DATE FILED (Month Day Year): May 6, 2002

33 MANNER OF DEATH: ☐ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide

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

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