

3

2003 116160

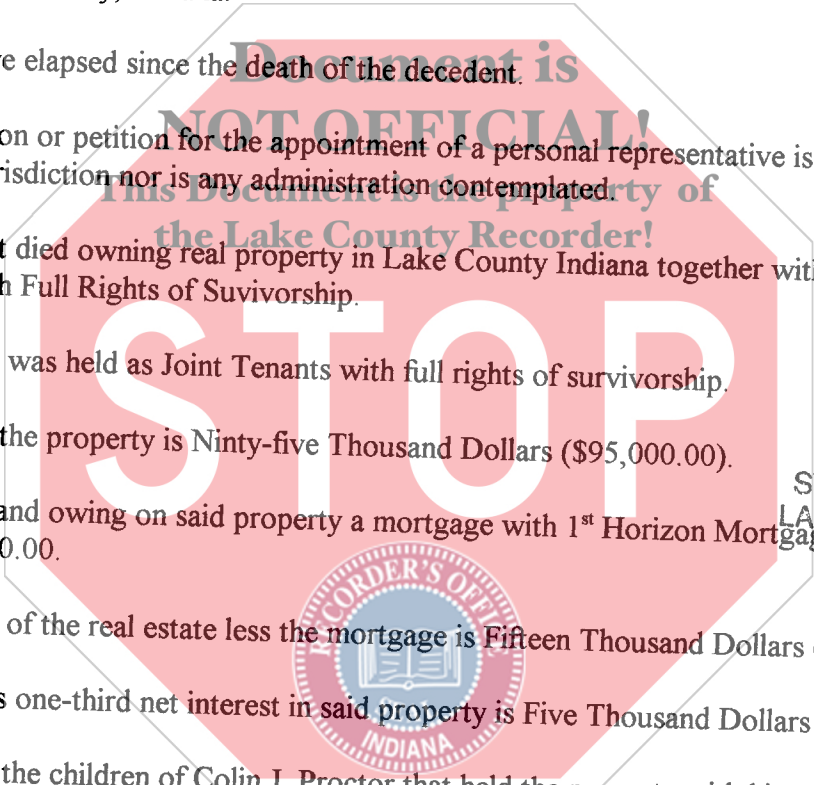
2003 OCT 29 11:35

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

IN RE: THE ESTATE OF
Colin J. Proctor, Deceased

**SURVIVORSHIP AFFIDAVIT AND
AFFIDAVIT FOR THE TRANSFER OF
REAL PROPERTY**

1. That the above-named decedent **Colin J. Proctor** died on the 2nd day of September, 2003, while domiciled in Lake County, Indiana.
2. That 45 days have elapsed since the death of the decedent.
3. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction nor is any administration contemplated.
3. That the decedent died owning real property in Lake County Indiana together with two of his children as Joint Tenants with Full Rights of Suvivorship.
4. That the property was held as Joint Tenants with full rights of survivorship.
5. That the value of the property is Ninty-five Thousand Dollars (\$95,000.00).
6. That there is due and owing on said property a mortgage with 1st Horizon Mortgage Company in the amount of \$80,000.00.
7. That the net value of the real estate less the mortgage is Fifteen Thousand Dollars (\$15,000.00)
8. That the decedents one-third net interest in said property is Five Thousand Dollars (\$5,000.00).
9. That the names of the children of Colin J. Proctor that held the property with him as joint tenants with full rights of suvivorship are: **Micky Anderson and Mary Anderson**, who survive the decedent.
10. That the value of interest transferred to each child is Twenty Five Hundred Dollars (\$2500.00), and is less than what is required to file an Indiana Inheritance Tax Return.



FILED
OCT 29 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

002415
7688
2.02
B. DG

11. That the description of the real property transferred is:

Lot one in Block One in Cressmoor Village, IN the City of Hobart, as per plat there of, recorded June 8, 1946 in Plat Book 27, Page 19 in the office of the Lake County Recorder

Common Address: 541 North Wisconsin Street, Hobart, Indiana.

12. That the individual entitled to the real estate as a result of the decedent's death, pursuant to: I.C. 32-1-2-7 are the surviving joint tenants, **Micky Anderson and Mary Anderson.**

13. That the gross value of the estate of the decedent as determined for the purposes of Federal Estate tax purposes is less than the value required for filing a form 706 Federal Estate Tax Return and an I.H. 6 Indiana Inheritance Tax Return is not required to be filed.

That this affidavit will hold the Assessor of Lake County harmless for its reliance on this affidavit, pursuant to Indiana Code 29-1-8-3 .

Dated this 27 day of October, 2003.

Document is NOT OFFICIAL!
James A. Proctor
James A. Proctor
This Document is the property of the Lake County Recorder!

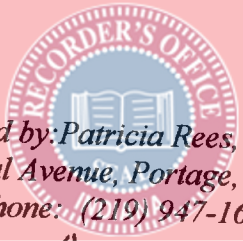
Before me a Notary Public appeared James A. Proctor and he did on this date swear to the truth of the foregoing statements.

Subscribed and sworn to before me this 27 day of October, 2003.

My Commission expires: March 25, 2010
Resident of Lake County

Patricia A. Rees
Patricia A. Rees, Notary Public

*This Instrument Prepared by: Patricia Rees, ATTORNEY AT LAW
5341 Central Avenue, Portage, IN 46368
Telephone: (219) 947-1692.*



1005 + 2vet

* 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

Local No. 2055-03

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First, Middle, Last) COLLIN J. PROCTOR		2 SEX Male	3a TIME OF DEATH 4:26 AM	3b DATE OF DEATH (Month, Day, Yr.) September 2, 2003	
4 *SOCIAL SECURITY NUMBER 368-26-1962	5a AGE—Last Birthday (Years) 74	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) March 25, 1929	
7 BIRTHPLACE (City and State or Foreign Country) Cheboygan Michigan	8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1950	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 checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b FACILITY NAME (If not institution, give street and number) 319 N. LaSalle Street		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) Joyce Sovo	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Millwright		12b KIND OF BUSINESS/INDUSTRY Steel	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Hobart		13d STREET AND NUMBER 319 N. LaSalle Street	
13e ZIP CODE 46342	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input 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) 12 College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) Hugh Proctor			19 MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Phillips		
20a INFORMANT'S NAME (Type/Print) Jim Proctor		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 N. LaSalle Street, Hobart, IN 46342		20c Relationship Son	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <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) Sep 5, 2003 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		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	
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. lung cancer					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. lung cancer DUE TO (OR AS A CONSEQUENCE OF)				Approximate Interval Between Onset and Death	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last b. DUE TO (OR AS A CONSEQUENCE OF)					
c. DUE TO (OR AS A CONSEQUENCE OF)					
d. DUE TO (OR AS A CONSEQUENCE OF)					
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) No	
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) as stated.					
29b SIGNATURE AND TITLE OF CERTIFIER <i>Mark O. Carter</i>		29c MEDICAL LICENSE NO. 01036415		29d DATE SIGNED (Month, Day, Year) 9/3/03	
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					
31 HEALTH OFFICER'S SIGNATURE <i>Stephen R. Stiglich</i> STEPHEN R. STIGLICH LAKE COUNTY ALTRATOR					
33 MANNER OF DEATH <input checked="" 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 DESCRIBE HOW INJURY OCCURRED 002410
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			