2

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 039212

2004 MAY 13 AM 9:07

MORRIS W. CARTER
RECORDER

TICOR TITLE INSURANCE

SURVIVORSHIP AFFIDAVIT

STATE OF: Indiana)
) SS:
COUNTY OF: Lake)

On this May 7, 2004 Before me personally appeared Onnalee R. Akers

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 Onnalee R. Akers
(state interest of affiant in the above premises as owner)
3. Said premises described as follows: Lot 44 in Aetna Estates in the City of Gary as per per plat thereof, recorded in Plat Book 31 page 42, in the Office of the Recorder of Lake County, Indiana.
41-292-44 (25)
4. Said premises were formerly owned as joint tenants or as tenants by entireties by Onnalee R. Akers and John R. Akers
5. Said John R. Akers
(fill in name of co-tenant who died)
died on October 4, 2000
leaving NO will;
(insert "a" or "no" if a will has been left, attach a copy)
6. 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 $_____ and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of the said descendent:
7. Where this affidavit relates to a tenancy of the entireties, were the parties ever divorced? NO
_____ (If answer is YES, identify the dissolution proceedings.) _____
8. Affiant's relationship to the deceased was wife

Signature Onnalee R. Akers
Address: Onnalee R. Akers

State of Indiana)
)
County of Lake)

Before me, the undersigned, a Notary Public in and for said County and State, this May 7, 2004 personally appeared Onnalee R. Akers

and acknowledged the execution of the foregoing Affidavit.

JUST ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
MAY 12 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Paula Barrick
Notary Public

PAULA BARRICK
Lake County
My Commission Expires
October 2, 2009

Resident of _____ County
My Commission expires: _____

Prepared by: Onnalee R. Akers

000594

TICOR MO 920042815

11 DC

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

Local No. 22261-00

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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.)
John	R.	Akers	Male	1:50 PM	October 4, 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)
310-30-6986	70			Apr 16, 1930	Valparaiso, IN

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	PLACE OF DEATH (Check only one See instructions)
Yes	N/A 1954	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
St. Mary Medical Center	Hobart	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	Onnalee Williams	Millwright	Steel Manufacturing

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Gary	5024 East 13th Place

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)	
46401-	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	Elementary/Secondary (0-12): 10	College (1-4 or 5+): N/A

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
John S. Akers	May Vail

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
Onnalee Akers	5024 East 13th Place, Gary, IN 46401	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 ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	October 8, 2000 Graceland Cemetery	Valparaiso, IN 46383-

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Martin L. Moeller	FD01019561	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
M. L. Moeller	FD01019561	Moeller Funeral Home FH83006821 104 Roosevelt Road, Valparaiso, IN

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. Lung Cancer
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

Approximate Interval Between Onset and Death

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

OCT 06 2000

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)
No	No	No

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) 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.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
by	01095-7785	10/6/00

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. PAUL Giannaris 1600 S Lake Park ave Hobart IN

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
Daniel L. Fulton, M.D.

32. DATE FILED (Month, Day, Year)
10/10/00

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.

State Form 10110 (R4/2-93) Destroy/PD-1