

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2004 039212

2004 MAY 13 AM 9:07

MORRIS W. CARTER  
RECORDER



**SURVIVORSHIP AFFIDAVIT**

STATE OF: Indiana )

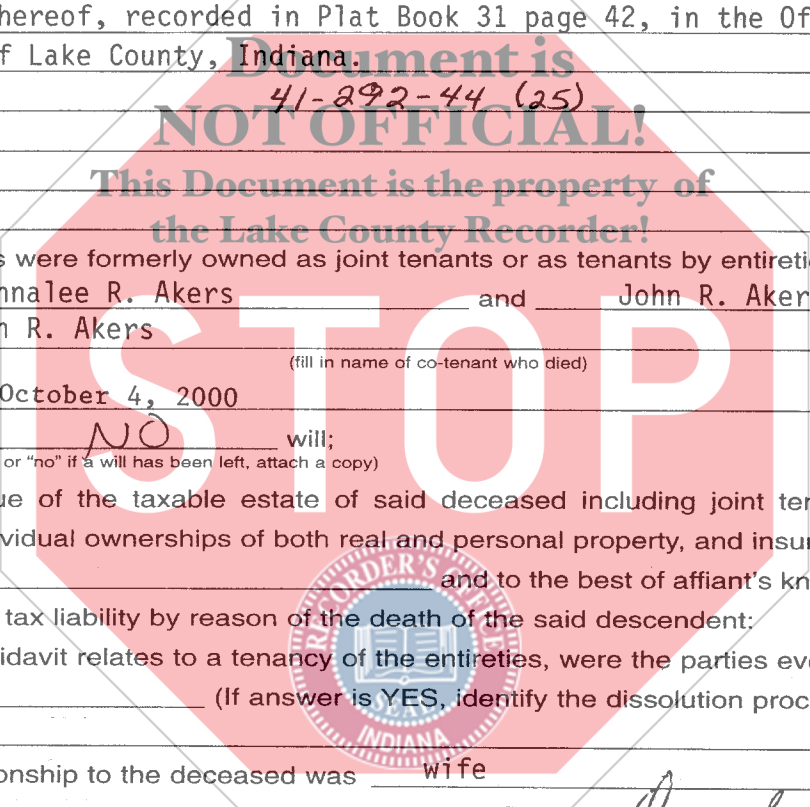
) SS:

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:

- Affiant resides at the address given below affiant's signature;
- Affiant is Onnalee R. Akers  
(state interest of affiant in the above premises as owner)
- 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)
- Said premises were formerly owned as joint tenants or as tenants by entireties by Onnalee R. Akers and John R. Akers
- 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)
- 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 decedent;
- Where this affidavit relates to a tenancy of the entireties, were the parties ever divorced? NO  
(If answer is YES, identify the dissolution proceedings.)
- Affiant's relationship to the deceased was wife



Signature Onnalee R. Akers  
Address: Onnalee R. Akers

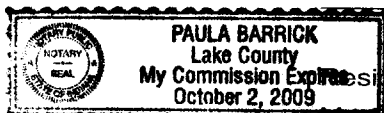
State of Indiana )  
County of Lake )

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

FILED FOR TAXATION SUBJECT TO  
FINAL ACCEPTANCE FOR TRANSFER

and acknowledged the execution of the foregoing Affidavit.

Paula Barrick  
STEPHEN R. STIGLICH  
Notary Public AUDITOR  
MAY 12 2004



President of \_\_\_\_\_ County  
My Commission expires: \_\_\_\_\_

Prepared by: Onnalee R. Akers

000894

11/50  
TJ

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

Local No. 2251-00

# 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

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED - NAME (First, Middle, Last) <b>John R. Akers</b>		2. SEX <b>Male</b>		3a. TIME OF DEATH <b>1:50 PM</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>October 4, 2000</b>	
4. * SOCIAL SECURITY NUMBER <b>310-30-6986</b>		5a. AGE - Last Birthday (Years) <b>70</b>		5b. UNDER 1 YEAR Months: _____ Days: _____		5c. UNDER 1 DAY Hours: _____ Minutes: _____	
6. DATE OF BIRTH (Mo., Day, Yr.) <b>Apr 16, 1930</b>		7. BIRTH-PLACE (City and State or Foreign Country) <b>Valparaiso, IN</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A 1954</b>		PLACE OF DEATH (Check only one See instructions)			
HOSPITAL: <input checked="" type="checkbox"/> Inpatient		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		<input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		<input type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) <b>St. Mary Medical Center</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Hobart</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Onnalee Williams</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) <b>Millwright</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Steel Manufacturing</b>	
13a. RESIDENCE - STATE <b>IN</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>5024 East 13th Place</b>	
13e. ZIP CODE <b>46401-</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>White</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed)					
Elementary/Secondary (0-12) <b>10</b>		College (1-4 or 5+) <b>N/A</b>					
18. FATHER'S NAME (First, Middle, Last) <b>John S. Akers</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>May Vail</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Onnalee Akers</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5024 East 13th Place, Gary, IN 46401</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <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) <b>October 8, 2000 Graceland Cemetery</b>		21c. LOCATION - City or Town, State <b>Valparaiso, IN 46383-</b>			
22a. EMBALMER'S NAME <b>Martin L. Moeller</b>		22b. EMBALMER'S LICENSE NO. <b>FD01019561</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR 		24b. LICENSE NUMBER (of Licensee) <b>FD01019561</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Moeller Funeral Home FH83006821 104 Roosevelt Road, Valparaiso, IN</b>			
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) <b>Lung Cancer</b>  Conditions, if any, which gave rise to the immediate cause stating the underlying cause last  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.		<b>STOP</b>		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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>			
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) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. MEDICAL LICENSE NO. <b>010-95-775</b>		29d. DATE SIGNED (Month, Day, Year) <b>10/6/00</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. PAUL Gianani 1600 S Lake Park ave Hobart IN</b>							
31. HEALTH OFFICER'S SIGNATURE 							
32. DATE FILED (Month, Day, Year) <b>October 6, 2000</b>							
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.					