

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

STATE OF INDIANA )  
                                  ) SS:  
COUNTY OF PORTER )

2004 042457

2004 MAY 21 11:58 AM

MERRIE PETERSON  
RECORDER

620042138

**AFFIDAVIT OF SURVIVORSHIP**

①

Chicago Title Insurance Company

Comes now Merrie Peterson, being duly sworn upon her oath, states as follows:

1. She is Personal Representative of the Estate of Robert J. Laster, which is currently pending in the Porter Superior Court Cause Number 64D01-0403-EU-2770. Robert J. Laster died on February 2, 2004.

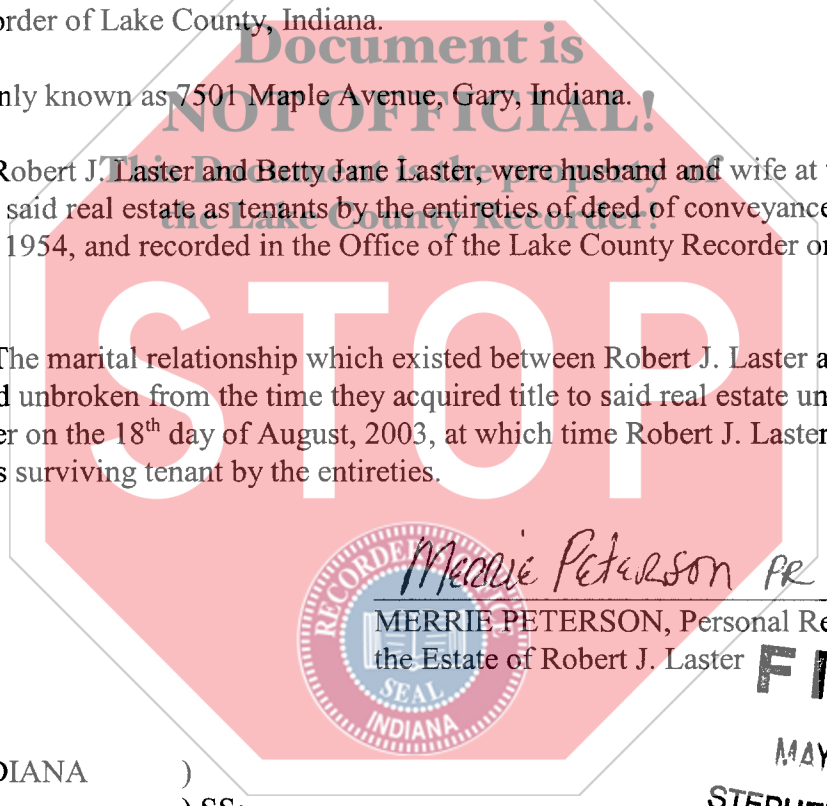
2. Robert J. Laster and Betty Jane Laster, his late wife, were the owners in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

The East 49 feet of Lot 6, in Block 10, in Norcotts Addition to Indiana City, in the City of GARY, as per plat thereof, recorded in Plat Book 1 page 14, in the Office of the Recorder of Lake County, Indiana.

Commonly known as 7501 Maple Avenue, Gary, Indiana.

3. Robert J. Laster and Betty Jane Laster were husband and wife at the time they acquired title to said real estate as tenants by the entireties of deed of conveyance dated the 21<sup>st</sup> day of October, 1954, and recorded in the Office of the Lake County Recorder on the 3<sup>rd</sup> day of January, 1955.

4. The marital relationship which existed between Robert J. Laster and Betty Jane Laster continued unbroken from the time they acquired title to said real estate until the death of Betty Jane Laster on the 18<sup>th</sup> day of August, 2003, at which time Robert J. Laster acquired title to the real estate as surviving tenant by the entireties.



*Merrie Peterson PR*  
MERRIE PETERSON, Personal Representative of  
the Estate of Robert J. Laster

**FILED**

MAY 20 2004

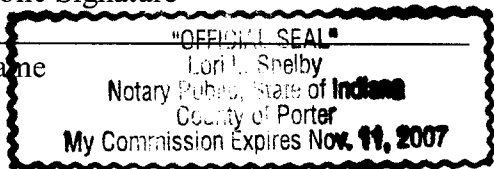
STEPHEN R. STIGLICH  
LAKE COUNTY AUDITOR

STATE OF INDIANA )  
                                  ) SS:  
COUNTY OF PORTER )

Before me the undersigned, a Notary Public for Porter County, State of Indiana, personally appeared Merrie Peterson, and she being first duly sworn by me upon her oath, says that the facts alleged in the foregoing instrument are true. Signed and sealed this 12 day of May, 2004.

*Lori L. Shelby*  
Notary Public Signature

Printed Name



County of Residence: \_\_\_\_\_  
Commission Expires: \_\_\_\_\_

13-  
67

ATTENTION: STATE DISCLOSURE OF THE SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

03 0615

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1, 19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

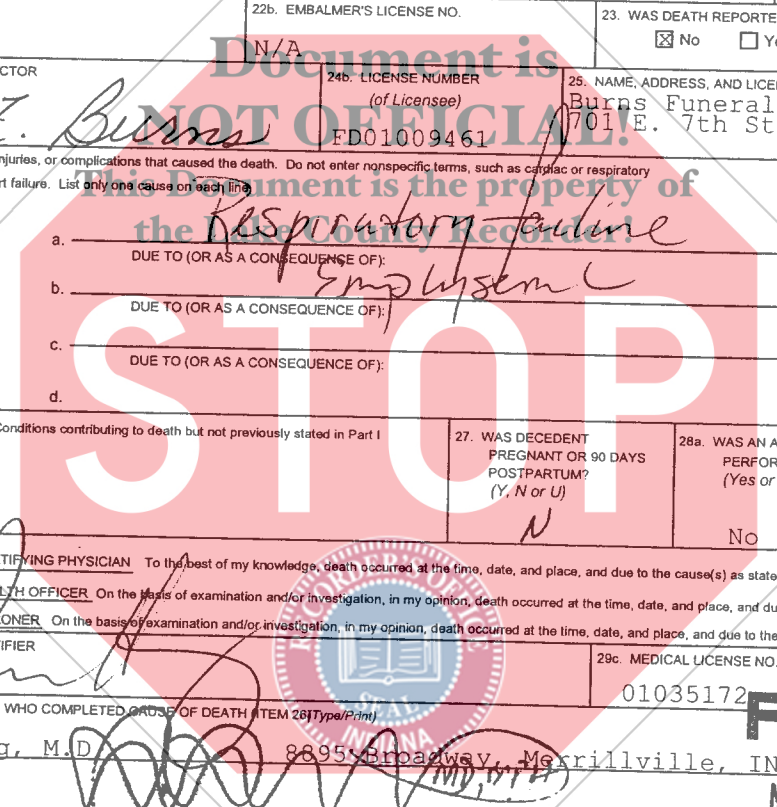
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) Betty J. Laster		2. SEX Female		3a. TIME OF DEATH 1:20 PM		3b. DATE OF DEATH (Month, Day, Yr.) August 18, 2003	
4. SOCIAL SECURITY NUMBER 312-16-4561		5a. AGE - Last Birthday (Years) 81		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo., Day, Yr.) December 25, 1921		7. BIRTHPLACE (City and State or Foreign Country) Keystone Oklahoma					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES?		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) 7501 Maple Avenue				9c. CITY, TOWN, OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Robert Laster		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Office Manager		12b. KIND OF BUSINESS/INDUSTRY Real Estate	
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Gary		13d. STREET AND NUMBER 7501 Maple Avenue	
13e. ZIP CODE 46403		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		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+) 1					
18. FATHER'S NAME (First, Middle, Last) Leroy Jacobs				19. MOTHER'S NAME (First, Middle, Maiden Surname) Lois Keith			
20a. INFORMANT'S NAME (Type/Print) Merrie Peterson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Barberry Lane, Valparaiso, IN 46383			20c. Relationship Daughter		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) August 20, 2003 NW Indiana Cremation Service			21c. LOCATION - City or Town, State Crown Point, Indiana		
22a. EMBALMER'S NAME N/A		22b. EMBALMER'S LICENSE NO. N/A		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-			
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)  Conditions, if any, which gave rise to the immediate cause stating the underlying cause last		a. DUE TO (OR AS A CONSEQUENCE OF): <i>Respiratory failure</i>				Approximate Interval Between Onset and Death	
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? (Y, N or U) N		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No	
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sharon Harig</i>		29c. MEDICAL LICENSE NO. 01035172		29d. DATE SIGNED (Month, Day, Year) 2-20-03			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Sharon Harig, M.D. 8695 Broadway, Merrillville, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Sharon Harig</i>							
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 THE INJURY		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) August 18, 2003				34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.			



FILED

MAY 20 2004 AUG 26 2003

STEPHEN STIGLICH LAKE COUNTY AUDITOR

This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT 155 Indiana Ave Suite 104 Valparaiso IN 46383

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-193

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

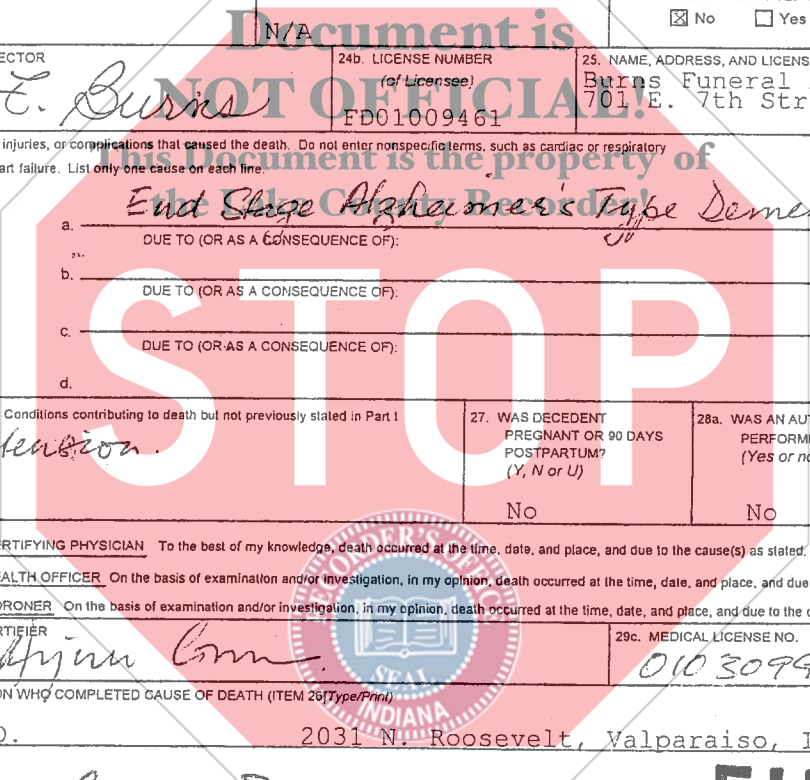
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED - NAME (First, Middle, Last) Robert Laster		2. SEX Male	3a. TIME OF DEATH 4:12 AM	3b. DATE OF DEATH (Month, Day, Yr.) February 2, 2004	
4. *SOCIAL SECURITY NUMBER 312-14-2546	5a. AGE - Last Birthday (Years) 80	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) March 26, 1923	
7. BIRTHPLACE (City and State or Foreign Country) South Bend Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		PLACE OF DEATH (Check only one See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) VNA Horton Hospice Center		9c. CITY, TOWN, OR LOCATION OF DEATH Valparaiso	9d. COUNTY OF DEATH Porter		
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.) Graphic Artist	12b. KIND OF BUSINESS/INDUSTRY U. S. Steel - Gary		
13a. RESIDENCE - STATE Indiana	13b. COUNTY Porter	13c. CITY, TOWN OR LOCATION Valparaiso	13d. STREET AND NUMBER 3301 N. Calumet		
13e. ZIP CODE 46383	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) Collage (1-4 or 5+) 12 N/A		18. FATHER'S NAME (First, Middle, Last) Walter Ray Laster			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Lucille Snok		20a. INFORMANT'S NAME (Type/Print) Merrie Peterson			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Barberry Lane, Valparaiso, IN 46383		20c. Relationship Daughter			
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) February 4, 2004 NW Indiana Cremation Service	21c. LOCATION - City or Town, State Crown Point, Indiana		
22a. EMBALMER'S NAME N/A		22b. EMBALMER'S LICENSE NO. N/A	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-		
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. <i>End Stage Alzheimer's Type Dementia.</i>				Approximate Interval Between Onset and Death <i>2 YRS</i>	
IMMEDIATE CAUSE (Final disease or condition resulting in death) 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.					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Hyperkalemia</i>					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) 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)		
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 <i>Arijun Gupta</i>		29c. MEDICAL LICENSE NO. 01030993	29d. DATE SIGNED (Month, Day, Year) 2/4/04		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Arijun Gupta M.D. 2031 N. Roosevelt, Valparaiso, IN 46383					
31. HEALTH OFFICER'S SIGNATURE <i>Henry A. Balabek MD</i>				32. DATE FILED (Month, Day, Year) February 5, 2004	
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"/> 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 <i>MI 20 2004</i>
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			34f. LOCATION (Street and Number or Rural Route Number, City, Town, State) <i>001-221</i>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) February 2, 2004		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.			



FILED February 5, 2004 001-221