

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 JUN -3 AM 9:38

2004 046458

MORRIS W. STIER
Tax Key Number: 10-52-126
Tax Unit Number: 11

Survivorship Affidavit

620040083

State of Indiana)
County of Lake) ss:

Alex J. Sanders, the Affiant, being first duly sworn, on his oath states:

Patricia R. Sanders held a life estate interest in the land legally described as follows:

Lot 1417 in Lakes of the Four Seasons, Unit 9, as per plat thereof, recorded in Plat Book 38, page 78, in the Recorder's Office of Lake County, Indiana.

Common address: 4031 Walnut Hill Circle
Crown Point, Indiana 46307

She died on August 21, 2003, as evidenced by the attached Death Certificate.

Affiant further sayeth not.

Signature of Affiant

Printed name of Affiant Alex J. Sanders

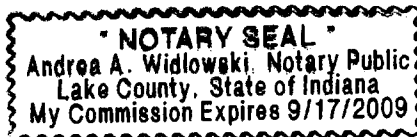
Subscribed and sworn to before me, a Notary Public in and for said County and State, this 28th day of May, 2004.

Signature of Notary Public

Printed Name of Notary Public

County of Residence of Notary Public

Commission expiration date of Notary Public



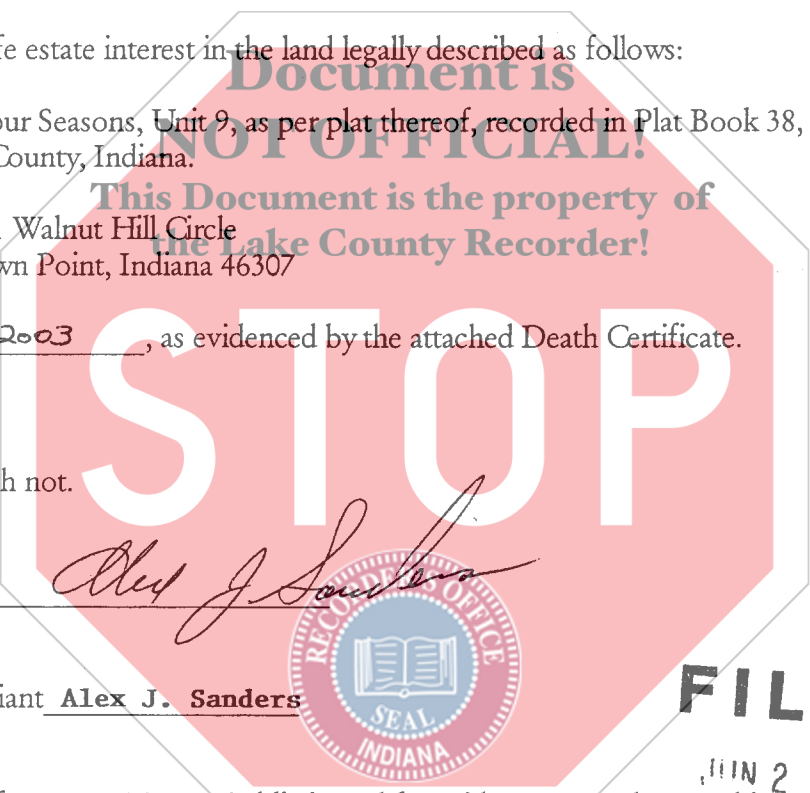
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JUN 2 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

This instrument was prepared by Alex J Sanders

000139

CHICAGO TITLE INSURANCE COMPANY



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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

Local No. 1993-03

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) PATRICIA R SANDERS		2. SEX Female	3a. TIME OF DEATH 9:40 PM	3b. DATE OF DEATH (Month, Day, Yr.) August 21, 2003	
4. *SOCIAL SECURITY NUMBER 307-30-7935	5a. AGE - Last Birthday (Years) 71	5b. UNDER 1 YEAR Months Days 0 0	5c. UNDER 1 DAY Hours Minutes 0 0	6. DATE OF BIRTH (Mo., Day, Yr.) February 12, 1932	7. BIRTHPLACE (City and State or Foreign Country) CURDSVILLE Kentucky
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 checked="" type="checkbox"/> Residence OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b. FACILITY NAME (If not institution, give street and number) 4031 WALNUT HILL CIRCLE		9c. CITY, TOWN, OR LOCATION OF DEATH CROWN POINT		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) ALEX SANDERS	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Secretary		12b. KIND OF BUSINESS/INDUSTRY GRIFFITH SCHOOLS	
13a. RESIDENCE - STATE Indiana	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION CROWN POINT		13d. STREET AND NUMBER 4031 WALNUT HILL CIRCLE	
13e. ZIP CODE 46307	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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+) N/A					
18. FATHER'S NAME (First, Middle, Last) WINDELL MATTINGLY			19. MOTHER'S NAME (First, Middle, Maiden Surname) MURIEL CAHLOUN		
20a. INFORMANT'S NAME (Type/Print) ALEX SANDERS		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4031 WALNUT HILL CIRCLE, CROWN POINT, IN		20c. Relationship Husband	
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 24, 2003 N.W. Ind. Cremation Services		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	
24. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME FH83002445 10101 Broadway, Crown Point, Indiana	
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. Metastatic lung cancer IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF): 19 mo 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)	
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>Stephen P. Stiglich</i>				29c. MEDICAL LICENSE NO. (Month, Day, Year) 0104571 LAKE COUNTY AUDITOR	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. MARION TRYBULA 200 E 89TH, MERRILLVILLE, IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>Marion Trybula D.O.</i>					
32. DATE FILED (Month, Day, Year) 2004					
33. MANNER OF DEATH <input 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. LOCATION (Street and Number or Rural Route Number, City or Town, State) 140
34e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34f. DATE PRONOUNCED DEAD (Month, Day, Year) August 21, 2003			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) August 21, 2003		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.			



FILED

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE ABOVE CAUSE OF DEATH AS FILED WITH THE LAKE COUNTY HEALTH DEPT