

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2004 077736

2004 SEP 14 AM 9:48

MORRIS J. STIGLICH
RECORDER

Chicago Title Insurance Company

Chicago Title Insurance Company

80351

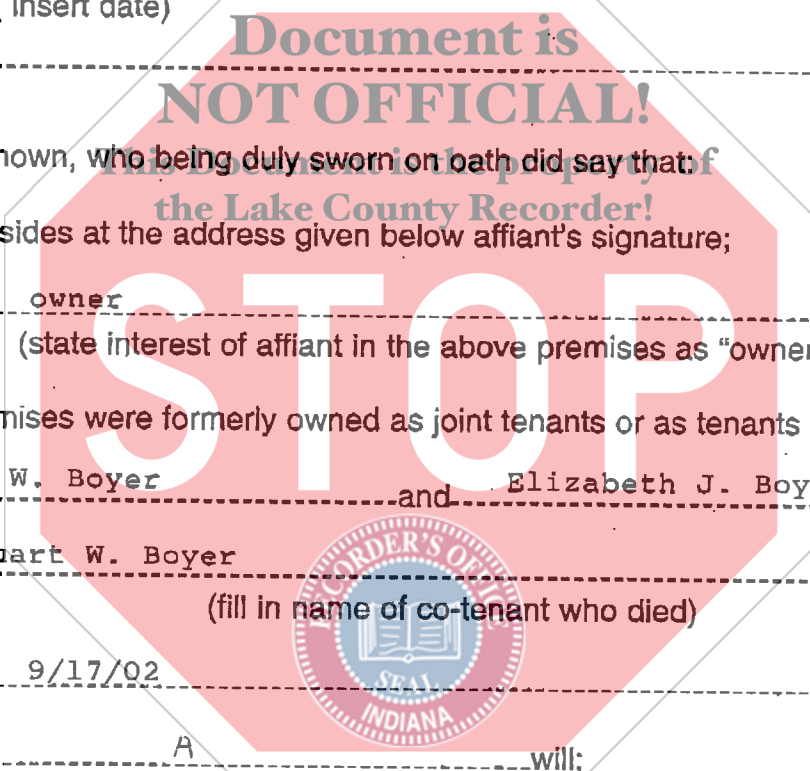
SURVIVORSHIP AFFIDAVIT

STATE OF

COUNTY OF

} s.s.

On this 8/25/04 before me personally appeared Elizabeth J. Boyer
(insert date)



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 owner;
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
- 3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Stuart W. Boyer and Elizabeth J. Boyer;
- 4. Said Stuart W. Boyer
(fill in name of co-tenant who died)
died on 9/17/02
leaving A will;
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:
LOT TEN (10) IN BLOCK TWO (2) IN KNICKERBOCKER MANOR 7TH ADDITION TO THE TOWN OF MUNSTER, LAKE COUNTY, INDIANA AS SHOWN ON THE PLAT RECORDED IN PLAT BOOK 32, AT PAGE 56, IN THE RECORDER'S OFFICE OF LAKE COUNTY, INDIANA. TAX ID# 18-28-195-10

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent: No

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

SEP 13 2004

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

CTIC Has made an accomodation recording of the instrument.

000922

Handwritten initials: ET, B, 20

7. Where this affidavit relates to a tenancy by the entirties, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:

_____);

8. Affiant's relationship to the deceased was wife

Signature: Elizabeth J. Boyer
Elizabeth J. Boyer

Address: 8501 Forest Ave., Munster, IN
46321

Subscribed and sworn to before me by the affiant

this 25th day of August, 2004

Stephanie Celestin
(insert date)

Notary Public

My Commission Expires Jan 20, 2012

This instrument prepared by Mercantile National Bank / M. Waechter



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. 1667-02

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) **Stuart W. Boyer Sr.** 2. SEX **Male** 3a. TIME OF DEATH **12:35P** 3b. DATE OF DEATH (Month, Day, Yr) **September 17, 2002**

4. SOCIAL SECURITY NUMBER **312-05-1410** 5a. AGE—Last Birthday (Years) **86** 5b. UNDER 1 YEAR **Months Days** 5c. UNDER 1 DAY **Hours Minutes** 6. DATE OF BIRTH (Mo, Day, Yr) **September 3, 1916** 7. BIRTHPLACE (City and State or Foreign Country) **Hammond, IN**

8a. WAS DECEDENT A U.S. VETERAN? **No** 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? **N/A** 9a. PLACE OF DEATH (Check only one. See instructions.)
 HOSPITAL: Inpatient ER/Outpatient DOA Residence
 OTHER: Nursing Home Other (Specify)

9b. FACILITY NAME (If not institution, give street and number) **8501 Forest Ave.** 9c. CITY, TOWN, OR LOCATION OF DEATH **Munster** 9d. COUNTY OF DEATH **Lake**

10. MARITAL STATUS (Specify) **Married** 11. SURVIVING SPOUSE (If wife, give maiden name) **Betty Peaker** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Business Owner** 12b. KIND OF BUSINESS/INDUSTRY **Meat**

13a. RESIDENCE—STATE **Indiana** 13b. COUNTY **Lake** 13c. CITY, TOWN, OR LOCATION **Munster** 13d. STREET AND NUMBER **8501 Forest**

13e. ZIP CODE **46321** 13f. INSIDE CITY LIMITS No Yes 13g. ON A FARM? No Yes 14. CITIZEN OF WHAT COUNTRY? **USA** 15. WAS DECEDENT OF HISPANIC ORIGIN? No 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) **Henry Fredrick Boyer** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **Anna Utte**

20a. INFORMANT'S NAME (Type/Print) **Betty Boyer** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **8501 Forest Munster, IN 46321** 20c. Relationship **Wife**

21a. METHOD OF DISPOSITION Burial Cremation Removal from State Donation Other (Specify) 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **September 20, 2002 Chapel Lawn** 21c. LOCATION—City or Town, State **Schererville, IN**

22a. EMBALMER'S NAME **David F. McCoy** 22b. EMBALMER'S LICENSE NO. **FD08700581** 23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *[Signature]* 24b. LICENSE NUMBER (of Licensee) **FD08700581** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **McCoy Funeral Chapel 83002877 5713 Hohman Ave. Hammond, IN 46320**

26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory, MI/MI, shock, or heart failure. List only one cause on each line. **THIS CERTIFIES THE IMMEDIATE CAUSE (Disease or condition resulting in death) Vascular collapse DUE TO (OR AS A CONSEQUENCE OF) arteriosclerotic heart and vascular disease**
 Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
 a. **9/17/02** DUE TO (OR AS A CONSEQUENCE OF)
 b.
 c.
 d.
 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) 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 *[Signature]* **Chief Deputy** 29c. MEDICAL LICENSE NO. **N/A** 29d. DATE SIGNED (Month, Day, Year) **September 19, 2002**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Jeffrey R. Wells, Chief Deputy, 2900 West 93rd Avenue, Crown Point, Indiana 46307**

31. HEALTH OFFICER'S SIGNATURE *[Signature]* 32. DATE FILED (Month, Day, Year) **September 19, 2002**

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

34a. 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) **September 17, 2002** 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.