(2)

taxes to PO Box 598, Schererville, IN 46375

2005 002971

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

KENNETH D. SKAGGS, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, KAREN S. SKAGGS died (without leaving a will) ~~(leaving a will)~~ on DECEMBER 12, 2004 20 04 at 3227 DULUTH ST., HIGHLAND, IN 46322

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

16-27-0279-0006

LOT 6 IN BLOCK 9 IN HOMESTEAD GARDENS MASTER ADDITION TO THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 32, PAGE 46 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of ~~(his)~~ (her) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

JAN 14 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Further affiant sayeth not.

x Kenneth D. Skaggs

Subscribed and sworn to before me, a Notary Public, this 30th day of December, 2004

KATHLEEN A. SHELINE
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY
MY COMMISSION EXP. JULY 28, 2012

Kathleen A Sheline
Notary Public

This instrument prepared by: KENNETH D. SKAGGS

BANKERS TITLE HAS MADE AN ACCOMMODATION RECORDING OF THE INSTRUMENT. WE HAVE MADE NO EXAMINATION OF THE INSTRUMENT OF THE LAND AFFECTED.

000686

Ck # 3972593 4
11 ⊗ XP

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.

Local No. 3004-04

INDIANA STATE DEPARTMENT OF HEALTH

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

COPY

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

Bankers Title

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
KAREN SUE SKAGGS	FEMALE	8:50 A M	DECEMBER 12, 2004

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)
328-48-3558	50					OCTOBER 9, 1954	YOUNGSTOWN, OHIO

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
NO	N/A	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
3227 DULUTH STREET	HIGHLAND	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	KENNETH SKAGGS	OFFICE MANAGER	MICROFILM

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	HIGHLAND	3227 DULUTH STREET

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) Elementary/Secondary (0-12)	College (1-4 or 5
46322	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	WHITE	12	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
DANA McCOURT	MARY BLAND

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
KENNETH SKAGGS	3227 DULUTH STREET, HIGHLAND, IN 46322	HUSBAND

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 ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment	DECEMBER 14, 2004 NORTHWEST INDIANA CREMATION SERVICES	CROWN POINT, INDIANA

22a. EMBALMER'S NAME:	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
NOT EMBLAMED	N/A	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Rick Miller	FD20400030	FAGEN MILLER FUNERAL HOME FH8300 2828 HIGHWAY AVENUE HIGHLAND, INDIANA 46322

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. — Approximate Interval Between Onset and D

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

Months

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

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
	01038072	12/13/04

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
DR. ROBIN 801 MACARTHUR BLVD. MUNSTER, IN.

31. HEALTH OFFICER'S SIGNATURE — Susan W Burt — DATE SIGNED (Month, Day, Yr.) December 1

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

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				DEC 13 2004

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.