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2005 JUN 14 10:10 AM

MICHAEL J. [unclear]  
REC'D

**Chicago Title Insurance Company**

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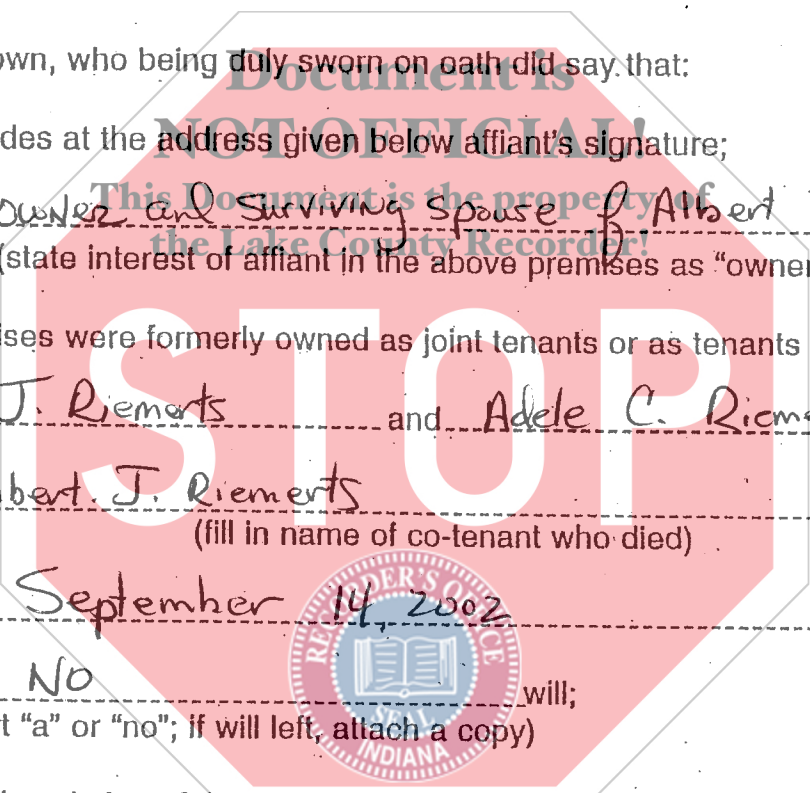
**SURVIVORSHIP AFFIDAVIT**

On this 31<sup>st</sup> day of May, 2005, before me personally appeared Adele C. Riemerts  
(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 and surviving spouse of Albert J. Riemerts;  
(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  
Albert J. Riemerts and Adele C. Riemerts;
4. Said Albert J. Riemerts  
(fill in name of co-tenant who died)  
died on September 14, 2002  
leaving No will;  
(insert "a" or "no"; if will left, attach a copy)
5. The legal description of the premises in question is:

6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent?     Yes     No  
If yes, then estimated taxes due are \$ \_\_\_\_\_  
The taxes due are     paid or     unpaid.



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

No

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

8. Affiant's relationship to the deceased was Spouse

Signature: Adele C. Liemerts

Printed Name Adele C. Liemerts

Address: 2193 Timberidge

Hightland IN 46322

Subscribed and sworn to before me by the affiant

this 31<sup>st</sup> day of May 2005  
(insert date)

[Signature]  
Notary Public

Printed Name William G. Crabtree II

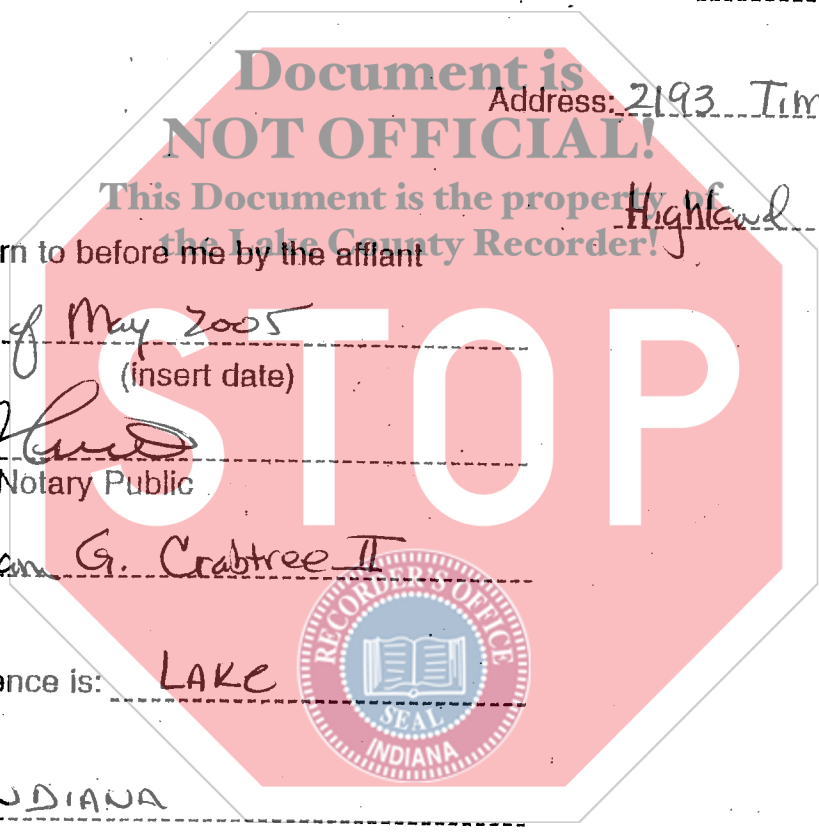
My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires 1-14-2008

This instrument prepared by William G. Crabtree II

222 INDIANAPOLIS BLVD, Ste 102  
Scharenville, IN 46375



ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to fulfill its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

Local No. 1654-02

142379

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) <b>Albert J. Riemerts</b>				2 SEX <b>Male</b>		3a TIME OF DEATH <b>2:04A</b> M		3b DATE OF DEATH (Month, Day, Yr.) <b>September 14, 2002</b>							
4 *SOCIAL SECURITY NUMBER <b>352-24-3896</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>Jan. 13, 1932</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Chicago, IL</b>					
8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N.A.</b>		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence							
9b FACILITY NAME (If not institution, give street and number) <b>2193 Timber Ridge</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>Highland</b>				9d COUNTY OF DEATH <b>Lake</b>							
10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Adele Probst</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Contractor</b>				12b KIND OF BUSINESS/INDUSTRY <b>Riemerts Construction</b>							
13a RESIDENCE—STATE <b>MI</b>		13b COUNTY <b>Van Buren</b>		13c CITY, TOWN OR LOCATION <b>South Haven</b>				13d STREET AND NUMBER <b>316 Eagle St.</b>							
13e ZIP CODE <b>49090</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</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>12</b> College (1-4 or 5+) <b>2</b>					
18 FATHER'S NAME (First, Middle, Last) <b>Albert Riemerts</b>						19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annette Roos</b>									
20a INFORMANT'S NAME (Type/Print) <b>Adele C. Riemerts</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>316 Eagle St. South Haven, MI 49090</b>				20c Relationship <b>Wife</b>							
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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>September 17, 2002</b> <b>Assumption Cemetery</b>				21c LOCATION—City or Town, State <b>Glenwood, IL</b>							
22a EMBALMER'S NAME <b>James Porras</b>				22b EMBALMER'S LICENSE NO. <b>1045964</b>				23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Buena</i>				24b LICENSE NUMBER (of Licensee) <b>1045184</b>				25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns-Kish Funeral Home #3004968</b> <b>8415 Calumet M/Jnster, IN (For Tews F.H. Homewood, IL Signature Only)</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) a <input checked="" type="checkbox"/> <b>Metastatic Prostate Cancer</b> DUE TO (OR AS A CONSEQUENCE OF) b <b>Acute Hypoxic Encephalopathy</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										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>---</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 <i>Christopher J. McIntyre D.O.</i>						29c MEDICAL LICENSE NO. <b>00001515</b>		29d DATE SIGNED (Month, Day, Year) <b>Sept. 18, 2002</b>							
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>C. McIntyre, D.O. 1573 N. Cline Griffith, IN 46319</b>															
31 HEALTH OFFICER'S SIGNATURE <i>Susan J. Best D.O.</i>										32 DATE FILED (Month, Day, Year) <b>September 18, 2002</b>					
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		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.											