STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

2005 049751

2005 JUN 15 AM 10:55

MICHAEL A. BROWN
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Comes now **DEXIE SKAGGS**, being duly sworn upon her oath and states as follows:

That Dexie Skaggs was the wife of Cassie J. Skaggs at the time they acquired title to the real estate commonly known as 2527 East 10th Street, Hobart, Lake County, Indiana 46342, and remained married to him until his death.

That Cassie J. Skaggs died on the eighth day of January, 1998, a resident of Lake County, State of Indiana, a copy of the death certificate of Cassie J. Skaggs is attached as Exhibit "A" hereto.

That the statements made in this Affidavit are true and complete insofar as the Affiant knows and are made for the purpose of establishing that Dexie Skaggs survived Cassie J. Skaggs.

Dexie Skaggs
DEXIE SKAGGS

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

I, the undersigned, a Notary Public in and for said County, in the State aforesaid, do hereby certify that on this day personally appeared before me, DEXIE SKAGGS, personally known to me to be the same person whose name is subscribed to the foregoing Instrument and personally known to me, and acknowledged that she signed, sealed and delivered the said Instrument as her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and notarial seal this 7th day of June, 2005.

Signed: _____
William G. Crabtree II (Notary Public)

My Commission Expires: 1/14/2008
My County of Residence: Lake

This Instrument prepared by William G. Crabtree II
WILLIAM G. CRABTREE II, P.C.
Attorney I.D. No. 16014-45
222 Indianapolis Blvd., Ste. 102, Schererville, Indiana 46375
Telephone: 219/864-3700; Facsimile 219/864-3710
e-Mail: wgcrab2@sbcglobal.net

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0042-98 State No.

20613

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
CASSIE SKAGGS	Male	11:47PM	January 8, 1998

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)
307-42-9237	59			Jun 21, 1938	Martha, Kentucky

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)
Yes	1967	HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Mary Medical Center	Hobart	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	Dexie Cantrell	Maintenance Supervisor	Steel

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	2527 E. 10th 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+)
46342	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Arthur Skaggs	Nannie Ferguson

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Dexie Skaggs	2527 E. 10th Street, Hobart, IN 46342	Wife

DISPOSITION

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 ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	Jan 12, 1998 Calumet Park Cemetery	Merrillville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FDO1006463	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FDO1006463	FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342

CAUSE OF DEATH

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 Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute MV coronal infarction DUE TO (OR AS A CONSEQUENCE OF)	4-2 hr
Conditions if any which gave rise to the immediate cause stating the underlying cause last	b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF)	unknown
	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)	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

CERTIFIER

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 Year)
John O. Carter MD	01017684	1-12-98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
John O. Carter MD, 295 S. Wisconsin Street, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE Alexander S. Pilipis MD — 32. DATE FILED (Month Day Year) January 12, 1998

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

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)
	JAN 12 1998

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.
	Alexander S. Pilipis MD COUNTY HEALTH COMMISSIONER

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

EXHIBIT A