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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2005 049785

SURVIVORSHIP AFFIDAVIT

2005 JUN 16 AM 11:32

MICHAEL A. [unclear]

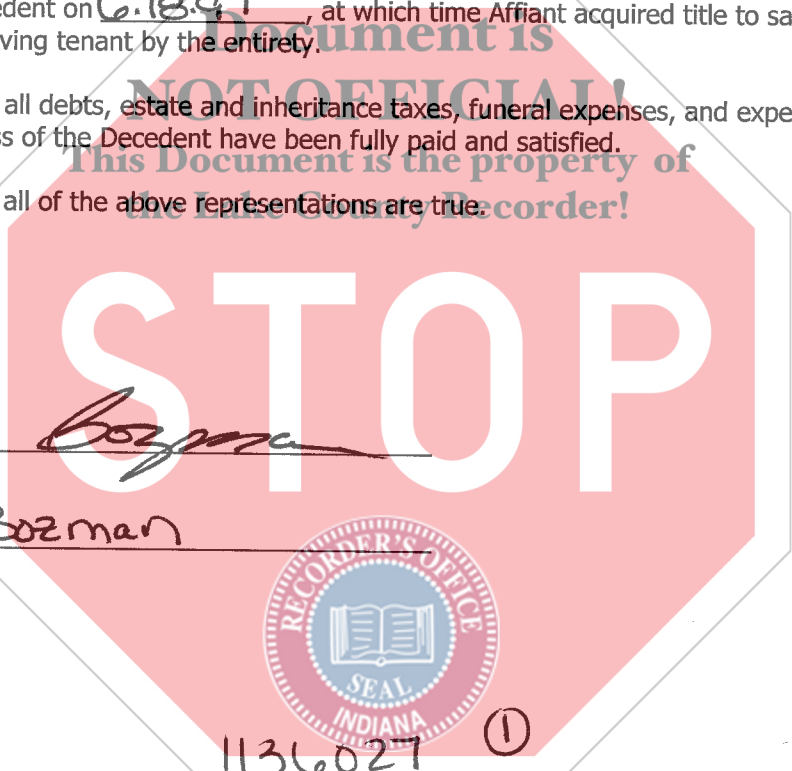
Roger D. Bozman ("Affiant"), being first duly sworn upon an oath, deposes and says:

1. That Mary M. Bozman ("the Decedent") and Affiant were husband and wife at the time they acquired title, as tenants by the entirety, to certain real estate by deed Recorded June 16, 1993, Document Number 93038786 in the Office of the Recorder of Lake County, Indiana, and more particularly described as follows:

20-76-15+16

 Lots 15 and 16 in Block 4, in Park Ridge Addition to Lake Station, as per plat thereof, recorded in Plat Book 12, page 27, in the Office of the Recorder of Lake County, Indiana.

 The address of the real estate is commonly known as 2260 Wayne Street, Lake Station, IN 46405.
2. That the marital relationship which existed between the Decedent and Affiant continued unbroken from the time they so acquired title to said real estate until the death of the Decedent on 6.18.97, at which time Affiant acquired title to said real estate as surviving tenant by the entirety.
3. That all debts, estate and inheritance taxes, funeral expenses, and expenses of the last illness of the Decedent have been fully paid and satisfied.
4. That all of the above representations are true.



AFFIANT:

Roger D. Bozman
Signature

Roger D. Bozman
Printed

FILED

JUN 16 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

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HOLD FOR THE TALON GROUP

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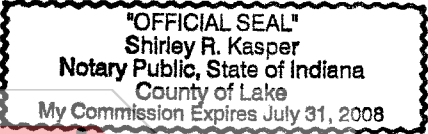
STATE OF INDIANA }
 }SS:
COUNTY OF Porter }

ACKNOWLEDGMENT

Before me the undersigned, a Notary Public in and for said County and State, personally appeared Roger D. Bozman who, being first duly sworn by me upon an oath, states that the facts alleged in the foregoing Survivorship Affidavit are true.

Witness my hand and Notarial Seal this 10th day of June, 2005.

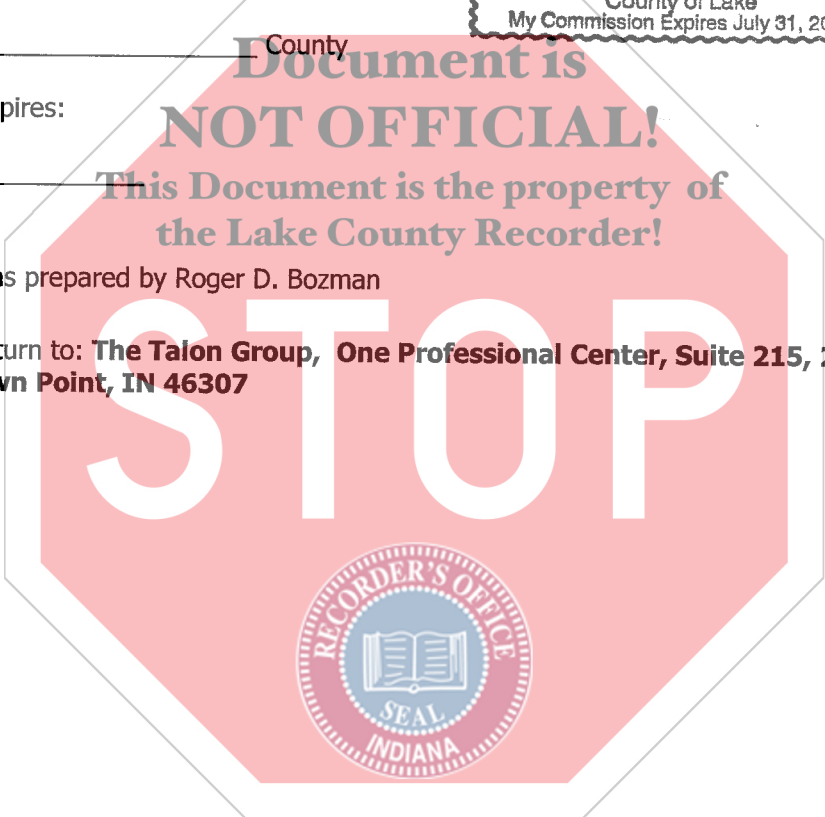
Shirley R. Kasper
Notary Public



Printed Name

Resident of _____ County

My Commission Expires: _____



This instrument was prepared by Roger D. Bozman

After recording, return to: **The Talon Group, One Professional Center, Suite 215, 2100 North Main Street, Crown Point, IN 46307**

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue (statutory) responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1400 AM

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) Mary M. Bozman		2. SEX Female	3a. TIME OF DEATH 8:00p	3b. DATE OF DEATH (Month, Day, Yr) June 18, 1997	
4. SOCIAL SECURITY NUMBER 303-48-4909	5a. AGE—Last Birthday (Years) 50	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) December 28, 1946	
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a. WAS DECEDENT A U.S. VETERAN? NO				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None		9a. PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c. CITY, TOWN, OR LOCATION OF DEATH Hobart	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Roger D. Bozman	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b. KIND OF BUSINESS/INDUSTRY Home	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Porter	13c. CITY, TOWN, OR LOCATION Portage	13d. STREET AND NUMBER 6440 Gaywood Ave.		
13e. ZIP CODE 46368	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) 11 College (1-4 or 5+) 0		18. FATHER'S NAME (First, Middle, Last) Frank Corbett			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Irene (Gabor) Corbett		20a. INFORMANT'S NAME (Type/Print) Roger D. Bozman			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6440 Gaywood Ave. Portage, IN 46368		20c. Relationship Husband			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <input 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) June 23, 1997 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, IN	
22a. EMBALMER'S NAME Philip Engel		22b. EMBALMER'S LICENSE NO. FD08800224		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Philip Engel</i>		24b. LICENSE NUMBER (of Licensee) FD09200094	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Engel Funeral Home FDH3007893 2700 Willowcreek Portage, IN463		
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cause of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE OF DEATH THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE REPORT OF THE CAUSE OF DEATH ON FILE WITH THE AS A CONSEQUENCE OF: LAKE COUNTY HEALTH DEPARTMENT.					
a. Reported, failure					
b. Renal failure					
c. Acute Superior Mesenteric artery thrombosis					
d. atherosclerotic vascular disease					
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) No	
29a. CERTIFIER (Check only one) <input 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 checked="" type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place as due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Philip Engel</i>			29c. MEDICAL LICENSE NO. 2090320	29d. DATE SIGNED (Month, Day, Year) 6-27-97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) L. J. E. Garner, Merrillville, IN					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander J. ... MD</i>					
32. DATE FILED (Month, Day, Year) July 6, 1997					
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigator <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.			