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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2005 053418

2005 JUN 28 10:38:07

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

50921B1

On this 15th Day of June, 2005 before me personally appeared
(insert date)

Evelyn M. Culp

CHICAGO TITLE INSURANCE COMPANY

to me personally known, who being duly sworn on oath did say that:

- Affiant resides at the address given below affiant's signature;
- Affiant is Owner
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
- Said premises were formerly owned as joint tenants or as tenants by the entireties by
DeWayne L. Culp and Evelyn M. Culp
- Said DeWayne L. Culp
(fill in name of co-tenant who died)
died on March 4, 2005
leaving NO will;
(insert "a" or "no"; if will left, attach a copy)
- The legal description of the premises in question is:

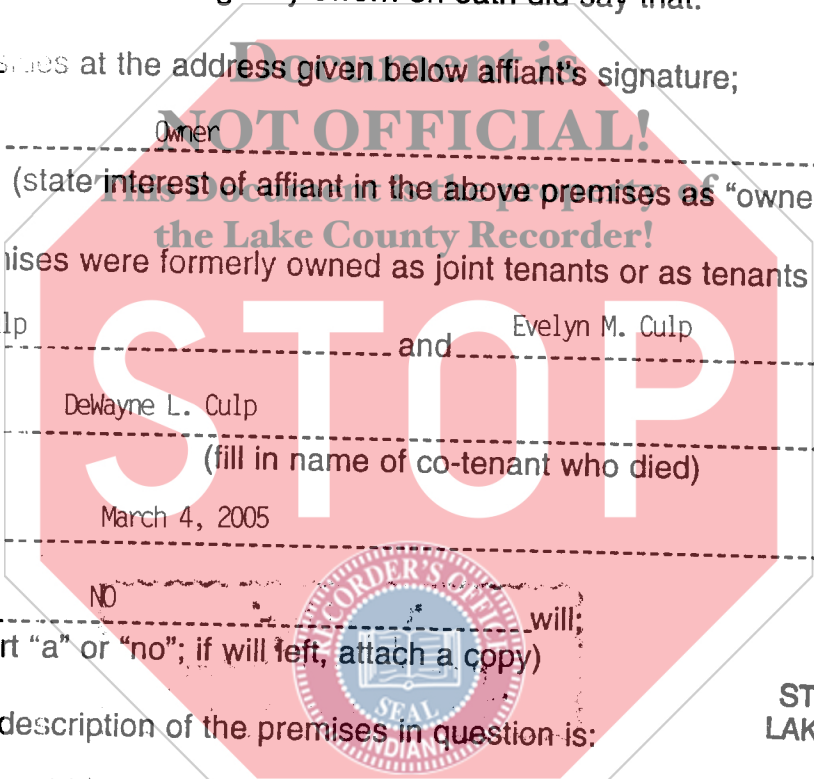
A part of the Southeast 1/4 of the Northwest 1/4 of Section 29, Township 33 North, Range 8 West of the second principal meridian, lying North of the Old State Road (Belshaw Road) described as follows: Commencing at the intersection of the centerline of said Old State Road and the East line of said quarter-quarter section, said point being the point of beginning; thence North along said East line 310 feet; thence West and parallel to the North line of said quarter-quarter section, 156.5 feet; thence Southwesterly 331 feet, more or less, to the centerline of said Old State Road; thence Northeasterly along said centerline 170 feet to the point of beginning.

6. Is there Federal Estate or State inheritance tax liability by reason of the death of said

decedent? Yes No

If yes, the estimated taxes due are \$ _____

The taxes due are paid or unpaid.



FILED

JUN 28 2005

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

002258

1300
CT
RM

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:

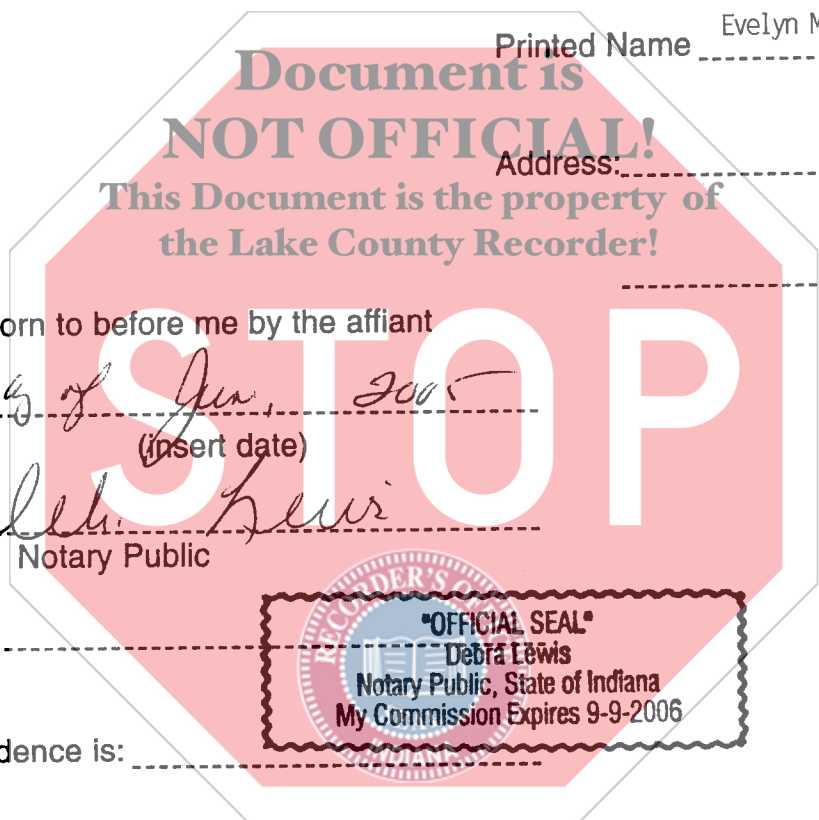
-----);

8. Affiant's relationship to the deceased was ----- wife -----

Signature: *Evelyn M. Culp*

Printed Name Evelyn M. Culp

Address: -----



Subscribed and sworn to before me by the affiant

this 15th day of Jan, 2005
(insert date)

Debra Lewis
Notary Public

Printed Name -----

My County of Residence is: -----

In the State of -----

My Commission Expires -----

This instrument prepared by Evelyn M. Culp

* 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

CERTIFICATE OF DEATH

State No.

Local No. 672-05

OTHER JURISDICTIONS ARE CIRCLED AND PREFIXED WITH

TYPE COUNTY IN PERMANENT BLACK INK

1. DECEASED'S NAME (Last, first, middle initial) DeWayne L. Culp	2. SEX Male	3a. TIME OF DEATH 06:04 PM	3b. DATE OF DEATH (Month, Day, Year) March 4, 2005
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4. SOCIAL SEC. IDENT. NUMBER 310-36-6797	5a. AGE - Last Birthday 67	5b. UNDER - YEAR Months: 00 Days: 00	5c. UNDER - DAY Hours: 00 Minutes: 00	6. DATE OF BIRTH (Month, Day, Year) June 19, 1937	7. BIRTHPLACE (City and State or Foreign Country) Indiana
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8a. WAS DECEDENT A U.S. VETERAN? YES	8b. YEAR LAST SERVED IN U.S. ARMED SERVICES 1963	9a. PLACE OF DEATH (Check available - See instructions) <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Other (Specify) Nursing Home	<input type="checkbox"/> Residence
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10. FACILITY NAME (Name, address, city, state and number) Lowell Healthcare Center	11. CITY, TOWN OR LOCATION OF DEATH Lowell	12. COUNTY OF DEATH Lake
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13a. MARITAL STATUS (Specify) Married	13b. SURVIVING SPOUSE (If wife, give maiden name) Evelyn Donley	13c. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steel Worker	13d. KIND OF BUSINESS/INDUSTRY Steel Mill
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14a. RESIDENT STATE Indiana	14b. COUNTY Lake	14c. CITY, TOWN OR LOCATION Lowell	14d. STREET AND NUMBER 2408 Belshaw Rd.
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15. ZIP CODE 46356	16. RACE (Check one) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other (Specify)	17. DECEASED'S EDUCATION (Specify any highest grade completed) 12
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18. FATHER'S NAME (First, Middle, Last) Clifford E. Culp	19. MOTHER'S NAME (First, Middle, Maiden Surname) Antoinette A. Fukan
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20a. INFORMANT'S NAME (Last, First) Evelyn M. Culp	20b. MAILING ADDRESS (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 2408 Belshaw Rd., Lowell, IN 46356	20c. Relationship Wife
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21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Mar 10, 2005 St. Edward's Cemetery	21c. LOCATION - City or Town, State Lowell IN
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22a. UMBRAL FUNERAL HOME Ken Sheets	22b. UMBRAL DEATH REPORT # (If different) FD08900045	22c. UMBRAL DEATH REPORT # (If different) FD08900045
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23a. SIGNATURE OF FUNERAL HOME EMPLOYEE Ken Sheets	23b. ADDRESS AND PHONE NUMBER OF FUNERAL HOME Sheets Funeral Home FH83004277 604 E. Commercial Ave. Lowell, IN 46356
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24. PART I - State the disease, injury, or complication that caused the death. Do not enter non-specific terms such as cardiac or respiratory arrest, or cause of death factors (e.g., trauma) as a cause of death.	25. APPROXIMATE PERIOD BETWEEN ONSET AND DEATH
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26. PART II - NAME OF CAUSE OF DEATH (Specify) Chronic Arteriosclerosis	27. ICD-10 CODE (Specify) I63.91
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28a. WERE ANY OTHER FACTORS A CONTRIBUTING CAUSE OF DEATH (Yes or No)? No	28b. WERE ANY OTHER FACTORS A CONTRIBUTING CAUSE OF DEATH (Yes or No)? No	28c. WERE ANY OTHER FACTORS A CONTRIBUTING CAUSE OF DEATH (Yes or No)? No
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29a. CERTIFIER (Check one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, based on records 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, I am reporting 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, I am reporting death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
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29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]	29c. MEDICAL LICENSE # 01030284	29d. DATE SIGNED (Month, Day, Year) 3/7/05
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Specify) Dr. Randall Hile MD 1020 E. Commercial Ave. Lowell, IN 46356
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31. SIGNATURE OF THE DECEASED (If available) [Signature]	32. DATE SIGNED (Month, Day, Year) [Signature]
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33. MANNER OF DEATH (Check one) <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	34a. DATE OF DEATH (Month, Day, Year) 3/4/05	34b. TIME OF DEATH (Hour, Minute) 06:04	34c. PLACE OF DEATH (Specify) Lowell, IN	34d. POLICE REPORT NUMBER (If furnished) 01030284
35a. PLACE OF INQUIRY - At home, farm, school, factory, office, building, etc. (Specify)	35b. LOCATION (Street and Number, or Rural Route Number, City or Town, State)			
36a. DATE PROCLAIMED DEAD (Month, Day, Year)	36b. MOTOR VEHICLE ACCIDENT (Yes or No) (If yes, specify driver, passenger, pedestrian, etc.)			

OPERATOR: (Specify) HEALTH OFFICER (Specify) CORONER (Specify) PHYSICIAN (Specify)

