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STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

2005 111729

2005 DEC 21 AM 9:50

AFFIDAVIT OF SURVIVORSHIP

MICHAEL ZORMIER
RECORDER
620058855

Comes now Michael Zormier, and upon being duly sworn does attest and say:

1. That the affiant is the son of Bob Dean Zormier and Phoebe M. Zormier, deceased.
2. That Bob Dean Zormier and Phoebe M. Zormier were the owners as Tenants by the Entirety of real property located in Lake County, Indiana, more particularly described as:

Lot 10 in block 13 in Country Club Estates Subdivision, in the City of Hobart, as per plat thereof, recorded in Plat Book 20 page 41, in the Office of the Recorder of Lake County, Indiana.

Common Address: 1237 Home Ave., Hobart, IN 46342
Key number: 27-17-0092-0010

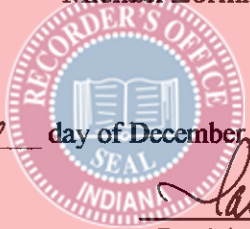
3. That Bob Dean Zormier and Phoebe M. Zormier acquired the property during the term of their marriage and remained married until the death of Phoebe M. Zormier.
4. That Phoebe M. Zormier died on the 20th day of February, 2004.
5. That the property vested in Bob D. Zormier upon the death of Phoebe M. Zormier.

I affirm under the penalties for perjury that the foregoing statements are true.

Michael Zormier
Michael Zormier

STATE OF INDIANA)SS:
COUNTY OF LAKE)

Subscribed and sworn to before me this 6 day of December, 2005.



Patricia A. Rees
Patricia A. Rees, Notary Public
Resident of Lake County

My Commission Expires: 03/25/10

This Instrument Prepared by: Patricia A. Rees, 5341 Central Ave. Portage, IN 46368 (219) 947-1692.

620058855-1
Chicago Title Insurance Company

FILED

DEC 20 2005

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

017051

1200
CT
M

Chicago Title Insurance Company

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

Local No. 512-04

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (Print, Middle Last) PHOEBE M. ZORMIER		2. SEX Female	3a. TIME OF DEATH 4:45 AM	3b. DATE OF DEATH (Month Day, Yr) February 20, 2004
4. SOCIAL SECURITY NUMBER 314-24-2624	5a. AGE—Last Birthday (Years) 75	5b. UNDER 1 YEAR Months Day	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month Day, Yr) June 19, 1928
7. BIRTHPLACE (City and State or Foreign Country) Hobart Indiana	8a. WAS DECEASED A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES N/A	9. PLACE OF DEATH (Cause only ONE. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> HOME <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> EN/Deployment <input type="checkbox"/> ODA <input type="checkbox"/> Residence	
10. FACILITY NAME (If not available, give street and number) Methodist Hospital Southlake		11. CITY, TOWN, OR LOCATION OF DEATH Merrillville		12. COUNTY OF DEATH Lake
13. MARITAL STATUS (Specify) Married	14. SURVIVING SPOUSE (If wife, give maiden name) Bob Zormier	15. DECEASED'S USUAL OCCUPATION (One kind of work done during most of working life. Do not use retired) Clerk		16. KIND OF BUSINESS/INDUSTRY Dry Cleaners
17a. RESIDENCE—STATE Indiana	17b. COUNTY Lake	17c. CITY, TOWN, OR LOCATION Hobart		17d. STREET AND NUMBER 1237 W. Home Avenue
18a. ZIP CODE 46342	18b. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	18c. CITIZEN OF WHAT COUNTRY? U.S.A.	18d. WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	18e. RACE—American Indian, Black, White, etc. (Specify) White
19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (1-12) 10		College (1-4 or 6-)		
10. FATHER'S NAME (Print Middle Last) Levi Cooper		11. MOTHER'S NAME (Print Middle Surname) Dolly Theadora Smith		
20a. INFORMANT'S NAME (Type/print) Bob D. Zormier		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1237 W. Home Avenue, Hobart, IN 46342		20c. Relationship Husband
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Buried from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Feb 24, 2004 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville IN
22. EMBALMER'S NAME James J. Krause		23. EMBALMER'S LICENSE NO. FD01006463		24. WAS DEATH REPORTED TO CORNER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
25. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		26. LICENSE NUMBER (If Licensed) FD01006463		27. HOME ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0498
28. PART I: IMMEDIATE CAUSE (Print disease or condition resulting in death) Advanced Coronary Artery Disease as a consequence of arteriosclerotic heart and cerebrovascular disease				
29. PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I dehydrated - 10h Semi-rig				
30. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place stated on this certificate. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place stated on this certificate. <input type="checkbox"/> CORONER On the basis of examination under circumstances of my control, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.		31. WAS DECEASED PREGNANT OR IN GAYS POSTPARTUM? (Yes or No) No		32. WAS AN AUTOPSY PERFORMED? (Yes or No) No
33. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) No		34. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> IN 25504 031 2005 25/2004		
35. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 2011) Krishnan Potti MD 8300 Broadway, Merrillville, IN 46410				
36. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i> INDIANA THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE HEALTH DEPARTMENT.				
37. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		38. DATE OF INJURY (Month, Day, Year) FILED DEC 20 2005		39. TIME OF INJURY (If yes or not) FEB 25 2004
40. PLACE OF INJURY—only home, farm, street, factory, other building, etc. (Specify)		41. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
42. DATE PROCLAIMED DEAD (Month, Day, Year)		43. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes specify driver, passenger, pedestrian, etc. PEGGY HOLINGA KATONA LAKE COUNTY AUDITOR		