

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

2006 075277

2006 AUG 28 PM 2: 21

MICHAEL A. BROWN
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Comes now Frances Trembicki, and upon being duly sworn does attest and say:

1. That the affiant is the daughter of Elsie H. Anderson and Gene N. Anderson, deceased.
2. That Elsie H. Anderson and Gene N. Anderson were the owners as Tenants by the Entirety of real property located in Lake County, Indiana, more particularly described as:

Lot 4, except the South 15 feet thereof, and except the North 30 feet thereof, in Block 3, in Garden Homes No. 2, as per plat thereof, recorded in Plat Book 25 page 73, in the Office of the Recorder of Lake County, Indiana.

Common Address: 3335 New Mexico St., Lake Station, IN 46405

3. That Elsie H. Anderson and Gene N. Anderson acquired the property during the term of their marriage.
4. That Gene N. Anderson died on the 27th day of April, 2005.
5. That Elsie H. Anderson died on the 19th day of February, 2002, as shown on the attached "Exhibit A".

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

Frances Trembicki
Frances Trembicki

STATE OF INDIANA)
)ss:
COUNTY OF LAKE)

FILED

AUG 28 2006

Subscribed and sworn to before me this 22 day of August, 2006.

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

My Commission
Expires: 03/25/2010

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

I affirm, under the penalties of perjury, that I have taken reasonable care to conduct each Social Security number in this document unless required by Law. *Patricia A. Rees*
This Instrument Prepared by: Patricia A. Rees, 5341 Central Ave., Portage, IN 46368 (219) 947-1692.

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* 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. 439-02

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) ELSIE H. ANDERSON		2. SEX Female	3a. TIME OF DEATH 2:05 PM	3b. DATE OF DEATH (Month, Day, Yr.) February 19, 2002	
4. SOCIAL SECURITY NUMBER 398-20-0776	5a. AGE—Last Birthday (Years) 78	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) February 4, 1924	
7. BIRTHPLACE (City and State or Foreign Country) Blue Island Illinois	8a. WAS DECEDENT A U.S. VETERAN? No				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c. 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			
9a. FACILITY NAME (If not institution, give street and number) 3335 New Mexico Street		9c. CITY, TOWN, OR LOCATION OF DEATH Lake Station	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Gene Anderson	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Punch Press Operator		12b. KIND OF BUSINESS/INDUSTRY Manufacturing	
13a. RESIDENCE—STATE IN	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Lake Station	13d. STREET AND NUMBER 3335 New Mexico Street		
13a. ZIP CODE 46405	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				
18. FATHER'S NAME (First, Middle, Last) Herbert Dost		19. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Wordelman			
20a. INFORMANT'S NAME (Type/Print) Gene Anderson		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3335 New Mexico Street, Lake Station, IN 46405	20c. Relationship Husband		
21a. METHOD OF DISPOSITION <input checked="" 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) Feb 22, 2002 Calvary Cemetery		21c. LOCATION—City or Town, State Portage IN	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. (of Licensee) FDO1006463	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488		
26. PART I. Enter the disease, 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. metastatic breast cancer		1 1/2 years	
b. DUE TO (OR AS A CONSEQUENCE OF)		c. DUE TO (OR AS A CONSEQUENCE OF)			
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		d. DUE TO (OR AS A CONSEQUENCE OF)			
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 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>Mary Klein MD</i>		29c. MEDICAL LICENSE NO. 01034294	29d. DATE SIGNED (Month, Day, Year) February 21, 2002		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Mary Klein MD 1190 N. State Road 49, Chesterton, IN 46304					
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. But. SO</i>		32. DATE FILED (Month, Day, Year) February 22, 2002			
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		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, 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? (Specify) anger, pedestrian, etc.			

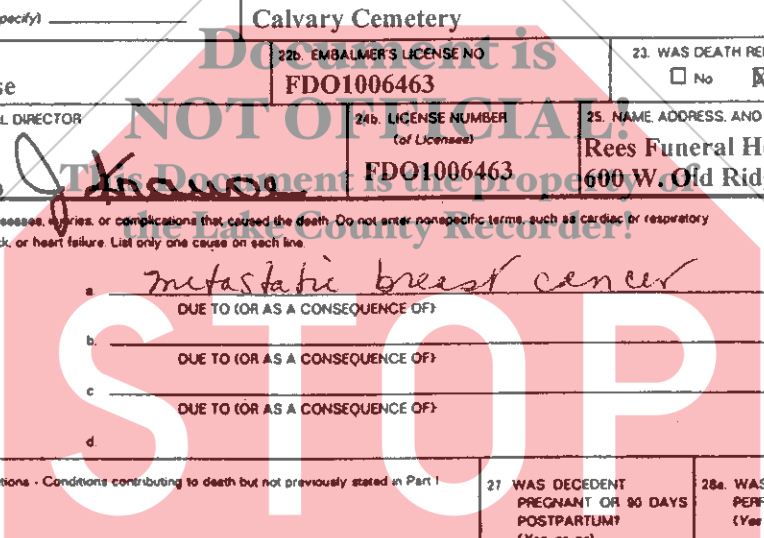


EXHIBIT "A"