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MICHAEL A. BROWN
RECORDER

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SURVIVORSHIP AFFIDAVIT

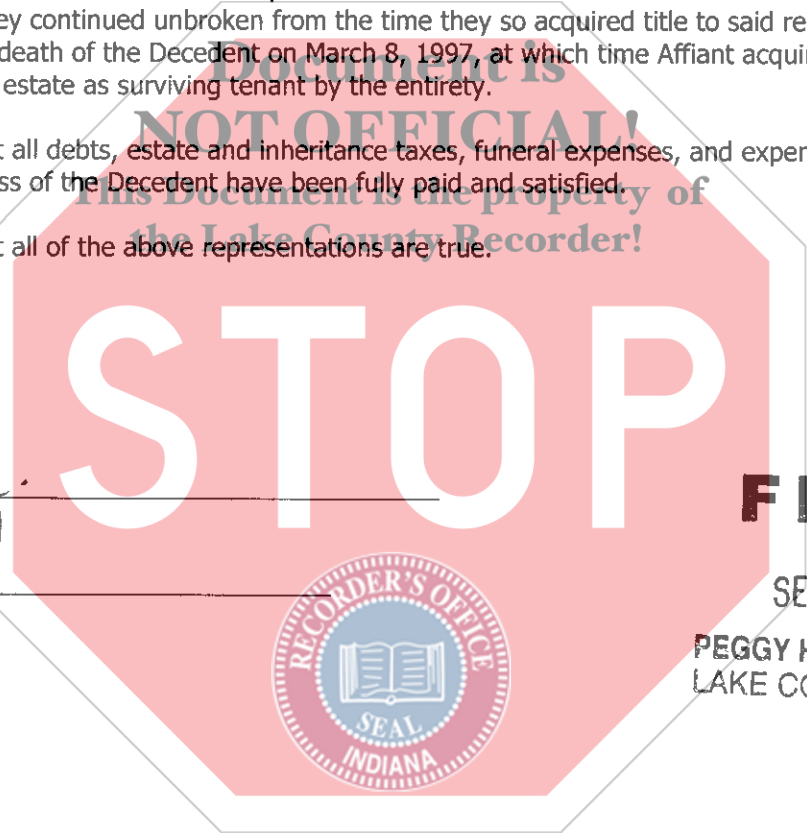
Kimberly K. Schultz ("Affiant"), being first duly sworn upon an oath, deposes and says:

1. That David L. Farley ("the Decedent") and Evelyn Farley were husband and wife at the time they acquired title, as tenants by the entireties, to certain real estate by deed Recorded January 14, 1997 Document No. 97003081 in the Office of the Recorder of Lake County, Indiana, and more particularly described as follows:

The North 1/2 of Lot 6, in Block 16 in the Railroad Addition to Crown Point, as per plat thereof, recorded in Miscellaneous Record "A", page 508, in the Office of the Recorder of Lake County, Indiana.

The address of the real estate is commonly known as 415 N. Grant Street, Crown Point, IN 46307.

2. That the marital relationship which existed between the Decedent and Evelyn Farley continued unbroken from the time they so acquired title to said real estate until the death of the Decedent on March 8, 1997, 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:

[Handwritten Signature]

Signature

Kimberly K. Schultz
Printed

FILED

SEP 20 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR



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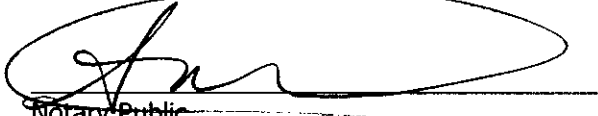
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T.G
JK

STATE OF INDIANA }
 }SS:
COUNTY OF Lake }

ACKNOWLEDGMENT

Before me the undersigned, a Notary Public in and for said County and State, personally appeared Kimberly K. Schultz 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 28th day of August, 2006.

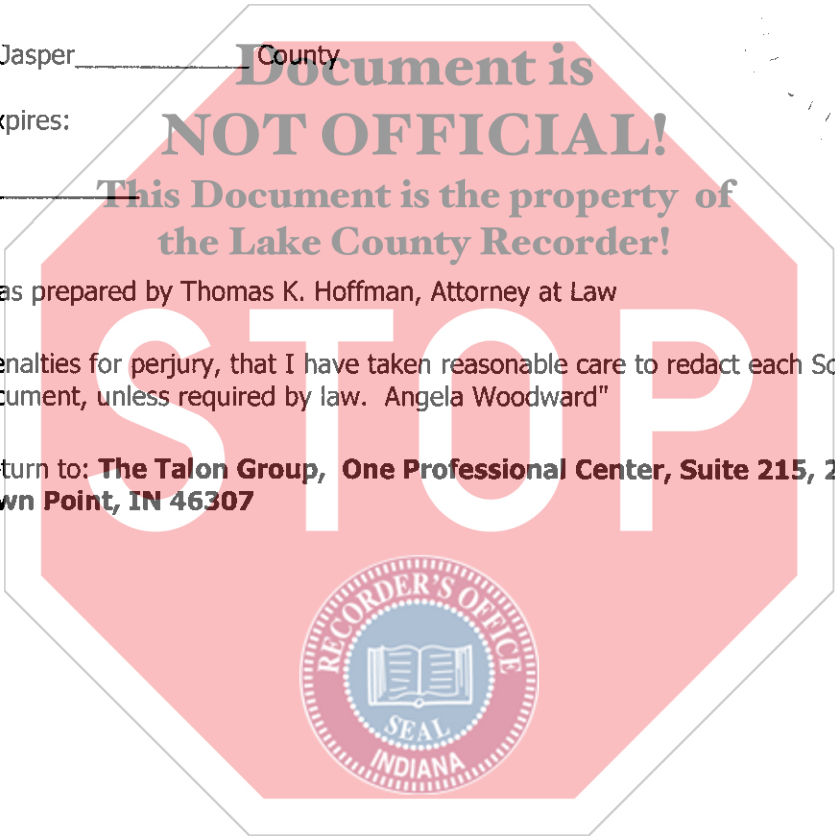

Notary Public

Angela Woodward
Printed Name

Resident of Jasper County

My Commission Expires:

1-11-08



This instrument was prepared by Thomas K. Hoffman, Attorney at Law

"I affirm, under penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law. Angela Woodward"

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

* ATENCIÓN ESTÁTE: 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. 0507-97

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <u>David L. Farley</u>		2 SEX <u>Male</u>		3a TIME OF DEATH <u>7:55 p.m.</u>		3b DATE OF DEATH (Month, Day, Yr.) <u>March 8, 1997</u>	
4 *SOCIAL SECURITY NUMBER <u>315-28-7752</u>		5a AGE—Last Birthday (Years) <u>67</u>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo. Day, Yr.) <u>FEB. 3, 1930</u>		7. BIRTHPLACE (City and State or Foreign Country) <u>Gary, Indiana</u>					
8a. WAS DECEDENT A U.S. VETERAN? <u>NO</u>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <u>N/A</u>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) <u>St. Anthony Medical Center</u>			9c. CITY, TOWN, OR LOCATION OF DEATH <u>Crown Point</u>		9d. COUNTY OF DEATH <u>Lake</u>		
10. MARITAL STATUS (Specify) <u>Married</u>		11. SURVIVING SPOUSE (If wife, give maiden name) <u>Evelyn Bannon</u>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Printer</u>		12b. KIND OF BUSINESS/INDUSTRY <u>Printing Company</u>	
13a. RESIDENCE—STATE <u>Indiana</u>		13b. COUNTY <u>Lake</u>		13c. CITY, TOWN, OR LOCATION <u>Crown Point</u>		13d. STREET AND NUMBER <u>120 E. Goldsboro</u>	
13a. ZIP CODE <u>46307</u>		13i. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>		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) <u>White</u>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u></u>					
18. FATHER'S NAME (First, Middle, Last) <u>Lawrence Farley</u>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hazel Miller</u>			
20a. INFORMANT'S NAME (Type/Print) <u>Evelyn Farley</u>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>120 E. Goldsboro Crown Point, IN 46307</u>			20c. Relationship <u>Wife</u>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <u>March 12, 1997</u> <u>Maplewood Memorial Cemetery</u>			21c. LOCATION—City or Town, State <u>Crown Point, Indiana</u>		
22a. EMBALMER'S NAME <u>Marty Andersen</u>		22b. EMBALMER'S LICENSE NO. <u>FD01005205</u>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <u>[Signature]</u>		24b. LICENSE NUMBER (of Licensee) <u>FD09000013</u>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <u>Geisen Funeral Home, Inc. FH83001253</u> <u>109 N. East St. Crown Point, IN 46307</u>			
26. PART I. THIS DEATH IS BEING REPORTED AS A RESULT OF A MEDICAL EXAMINATION OR AUTOPSY. On each line, state the cause or causes that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) <u>Acute Pulmonary Embolism</u> Approximate Interval Between Onset and Death <u>Few hours</u> Conditions, if any, which give rise to the immediate cause, stating the underlying cause last <u>MAR 10 1997</u> DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF)							
PART II. Other medical conditions: Conditions contributing to death but not previously stated in Part I. <u>Carcinoma - Right Kidney</u> <u>COAD - Chronic</u>							
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) <u>No</u>							
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <u>No</u>							
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <u>No</u>							
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 <u>[Signature]</u>			29c. MEDICAL LICENSE NO. <u>19528</u>		29d. DATE SIGNED (Month, Day, Year) <u>Mar. 10, 1997</u>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <u>Debbie F. Carpenter M.D. 123 N. Court - Crown Point, Ind 46307</u>							
31. HEALTH OFFICER'S SIGNATURE <u>[Signature]</u>						32. DATE FILED (Month, Day, Year) <u>March 10, 1997</u>	
33. MANNER OF DEATH <input 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		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.			

