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STATE OF INDIANA)
) SS: IN RE: MARY E. KEPSHIRE
COUNTY OF LAKE)

Key # 23-09-0320-0010

AFFIDAVIT FOR TRANSFER OF REAL PROPERTY

1. That the above-named decedent died intestate on February 5, 2003, while domiciled in Lake County.

2. That forty-five (45) days have elapsed since the death of the decedent.

3. That no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction, or is contemplated to be filed.

4. That the following named persons are the only heirs of the decedent:

Donna S. Kepshire-Ricketts Daughter
511 N. West Street
Crown Point, Indiana 46307

John Kepshire Son
509 Robyn
Valparaiso, Indiana 46385

Thomas Kepshire Son
2506 Bertrand Street
South Bend, Indiana 46628

Carol Vandercar Daughter
19102 Harrison Street
Lowell, Indiana 46356

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PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of Twenty-Five Thousand Dollars ($25,000.00), as provided under I.C. 29-1-8-3, the costs of expenses of administration and reasonable funeral expenses. In fact, the value of the decedent's gross probate estate is zero.

6. That the decedent is in title, along with her daughter, Donna Kepshire-Ricketts, to a parcel of real estate located in lake County, Indiana more particularly described as follows:

$17
MT
CA

The north 48 feet of the following described real estate to wit: part of the East 1/2 of the Southwest 1/4 of section 5, Township 34 North, Range 8 West of the 2nd principal meridian, in the City of Crown Point, Lake County, Indiana, commencing at the point of intersection of the West Line of West Street with the North Line of Goldsborough St. and

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HOLD FOR MERIDIAN TITLE CORP

running thence West 120 feet more or less, to the John Loague Lot; thence North along the East line of said John Loague Lot 198 feet; thence East 120 feet; more or less, to the West line of West Street; thence South along said West line of West Street 198 feet to the place of beginning.

7. That the following list of persons, firms, or corporations are the only creditors of the estate and the amount set opposite each name is the sum due said creditor, so far as the same is known to the affiant.

None.

8. That the individuals who may assert an interest to the real estate as a result of the decedent's death are the decedent's heirs at law as provided under the laws of intestate succession, namely:

Donna Kepshire-Ricketts Daughter
511 N. West Street
Crown Point, Indiana 46307

John Kepshire Son
509 Robyn
Valparaiso, Indiana 46385

Thomas Kepshire Son
2506 Bertrand Street
South Bend, Indiana 46628

Carol Vandercar Daughter
19102 Harrison Street
Lowell, Indiana 46356

9. That by reason of the above-stated matters, the affiant requests that any interest of the decedent in the above-listed real estate be transferred to the above-listed heirs at law equally pursuant to the laws of intestate distribution, in accordance with the provisions of I.C. 29-1-8-3.

Donna S. Kepshire-Ricketts

Donna S. Kepshire-Ricketts, Affiant

STATE OF INDIANA)
) SS: ACKNOWLEDGMENT
COUNTY OF LAKE)

Before me, a Notary Public in and for said County and State, personally appeared Donna S. Kepshire-Ricketts, who acknowledged the execution of the foregoing instrument, and who,

having been duly sworn, stated that any representations therein contained are true. Witness my hand and Notarial Seal this 26 of October, 2006.

My commission expires:

5/31/08

Linda R. Kafkowski, Notary Public

Lake County Resident

This instrument prepared by: Stephanie Shappell Katich, Attorney at Law, #21297-38
Katich & Shappell Legal Team, LLP
1201 North Main Street, Suite A
Crown Point, IN 46307

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

Prepared By
Stephanie Shappell Katich, Attorney at Law

336-03

CERTIFICATE OF DEATH

State No. .....

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

RINT / IENT / INK

1 DECEASED—NAME (First, Middle, Last): **Mary E. Kepshire**

2 SEX: **Female**

3a TIME OF DEATH: **11:15 AM**

3b DATE OF DEATH (Month, Day, Yr.): **February 5, 2003**

4 SOCIAL SECURITY NUMBER: [redacted]1643

5a AGE—Last Birthday (Years): **71**

5b UNDER 1 YEAR (Months, Days):

5c UNDER 1 DAY (Hours, Minutes):

6 DATE OF BIRTH (Mo, Day, Yr.): **October 14, 1931**

7 BIRTHPLACE (City and State or Foreign Country): **Chicago IL**

8a WAS DECEDENT A U.S. VETERAN? **No**

8b YEAR LAST SERVED IN U.S. ARMED FORCES? **N/A**

9a PLACE OF DEATH (Check only one. See instructions.)
HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA
OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number): **Methodist Hospital Southlake Campus**

9c CITY, TOWN OR LOCATION OF DEATH: **Merrillville**

9d COUNTY OF DEATH: **Lake**

10 MARITAL STATUS (Specify): **Widowed**

11 SURVIVING SPOUSE (If wife, give maiden name): **N/A**

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): **Clerical Worker**

12b KIND OF BUSINESS/INDUSTRY: **Medical**

13a RESIDENCE—STATE: **Indiana**

13b COUNTY: **Lake**

13c CITY, TOWN, OR LOCATION: **Crown Point**

13d STREET AND NUMBER: **511 N. West St.**

13e ZIP CODE: **46307**

13f INSIDE CITY LIMITS: [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? **USA**

15 WAS DECEDENT OF HISPANIC ORIGIN? [X] No [ ] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)

16 RACE—American Indian, Black, White, etc. (Specify): **Caucasian**

17 DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): **12**
College (1-4 or 5 +): **1**

18 FATHER'S NAME (First, Middle, Last): **John Hepp**

19 MOTHER'S NAME (First, Middle, Maiden Surname): **Ethel Taylor**

20a INFORMANT'S NAME (Type/Print): **Donna S. Kepshire**

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): **511 N. West St., Crown Point, IN 46307**

20c Relationship: **Daughter**

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____ [ ] Entombment

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): **Feb 8, 2003 Lowell Memorial Cemetery**

21c LOCATION—City or Town, State: **Lowell IN**

22a EMBALMER'S NAME: **Molly E. Hawkins**

22b EMBALMER'S LICENSE NO: **FD09200061**

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Ken Sheets

24b LICENSE NUMBER (of Licensee): **FD08900045**

25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: **Sheets Funeral Home FH83004277 644 E. Commercial Ave. Lowell, IN 46356**

26 PART I. Enter the diseases, 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	Chronic Obstructive Lung disease	2 years
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b	DUE TO (OR AS A CONSEQUENCE OF): Atrial fibrillation	1 year.
c	DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus	
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)
[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.
[ ] 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.
[ ] 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) as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: M Prasad

29c MEDICAL LICENSE: 01032446

29d DATE SIGNED (Month, Day, Year): 2/9/03

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): **Mirdula Prasad M.D. 9250 Columbia Suite C1, Munster, IN 46321**

31 HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.

31a DATE SIGNED (Month, Day, Year): January 12, 2003

33 MANNER OF DEATH: [X] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] 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, 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.

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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