

STATE OF INDIANA  
LAKE COUNTY  
FILED 2007 JUN 26

2007 JUN 26 AM 10:56

MICHAEL A. DOWD  
RECORDER

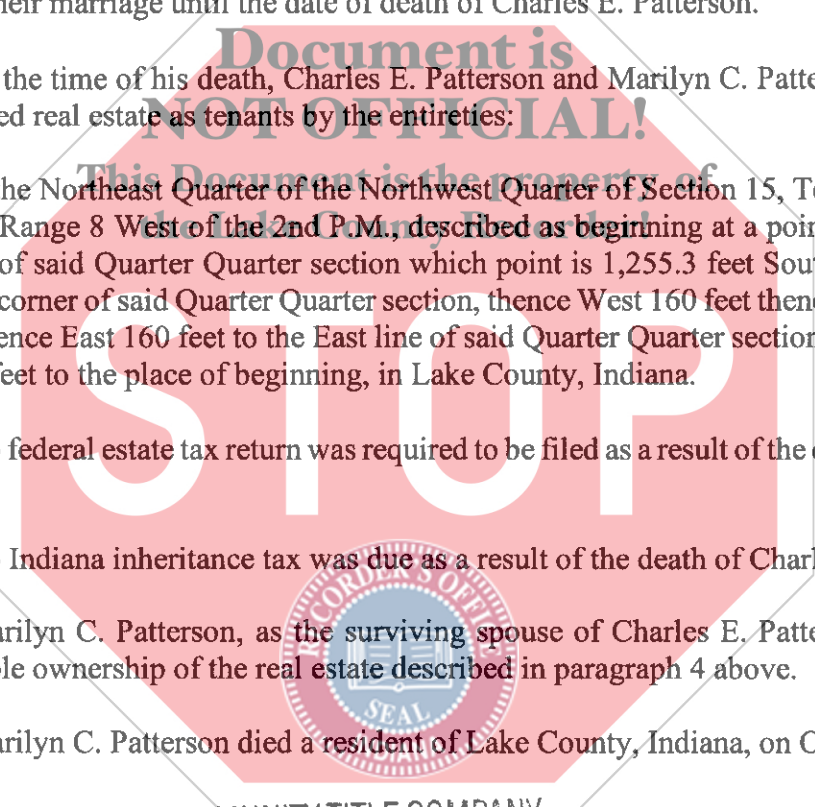
2007 051958

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

**SURVIVORSHIP AFFIDAVIT**

Sherry L. Yagodnik, 9060 Nautical Watch Drive, Indianapolis, IN 46236, being duly sworn upon her oath, states as follows:

1. Charles E. Patterson and Marilyn C. Patterson were married on February 26, 1944.
2. Charles E. Patterson died a resident of Lake County, Indiana, on October 24, 2004.
3. Charles E. Patterson and Marilyn C. Patterson lived continuously as husband and wife from the date of their marriage until the date of death of Charles E. Patterson.
4. At the time of his death, Charles E. Patterson and Marilyn C. Patterson owned the following described real estate as tenants by the entireties:  
  
A part of the Northeast Quarter of the Northwest Quarter of Section 15, Township 35 North, Range 8 West of the 2nd P.M., described as beginning at a point on the East Line of said Quarter Quarter section which point is 1,255.3 feet South of the Northeast corner of said Quarter Quarter section, thence West 160 feet thence North 80 feet; thence East 160 feet to the East line of said Quarter Quarter section; thence South 80 feet to the place of beginning, in Lake County, Indiana.
5. No federal estate tax return was required to be filed as a result of the death of Charles E. Patterson.
6. No Indiana inheritance tax was due as a result of the death of Charles E. Patterson.
7. Marilyn C. Patterson, as the surviving spouse of Charles E. Patterson, was fully vested in fee simple ownership of the real estate described in paragraph 4 above.
8. Marilyn C. Patterson died a resident of Lake County, Indiana, on October 6, 2006.



**FILED**

COMMUNITY TITLE COMPANY

FILE NO 2 37743

15.00  
P.P.M.  
C.M.

JUN 22 2007

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

008298

9. At the time of her death, Marilyn C. Patterson owned the real estate described in paragraph 4 above in fee simple ownership.

10. No federal estate tax return was required to be filed as a result of the death of Marilyn C. Patterson.

Dated this 19th day of June, 2007.

X Sherry L. Yagodnik  
Sherry L. Yagodnik

STATE OF INDIANA        )  
                                  ) SS:  
COUNTY OF LAKE        )

Before me the undersigned, a Notary Public for Porter County, State of Indiana, personally appeared Sherry L. Yagodnik, and she being first duly sworn by me upon her oath, says that the facts alleged in the foregoing instrument are true.

WITNESS MY HAND AND SEAL this 19th day of June, 2007.

My commission expires 11/29/2013  
Resident of Porter County

Barry W. Pruett, Notary Public

**This Document is the property of  
the Lake County Recorder!**

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. Barry W. Pruett

This instrument was prepared by:  
Barry W. Pruett, Attorney Number 25748-64  
Burke Costanza & Cuppy LLP  
57 Franklin, Suite 203, Valparaiso, IN 46383  
Tel. No.: 219.531.0134



ATTENTION: The Social Security # is being requested by this state agency in order to issue 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. 2624-09.....

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

TYPE/PRINT IN PERMANENT INK

1. DECEASED—NAME (First, Middle, Last) <b>Charles E. Patterson</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>9:00a.m</b>	3b. DATE OF DEATH (Month, Day, Year) <b>October 24, 2004</b>	
4. SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) <b>80</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) <b>June 14, 1924</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>
8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---		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) <b>Methodist Hospital Southlake Campus</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>		9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Marilyn C. Freiss</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Supervisor</b>		12b. KIND OF BUSINESS/INDUSTRY <b>U.S. Steel</b>	
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Merrillville</b>		13d. STREET AND NUMBER <b>7035 Carolina Place</b>	
13e. ZIP CODE <b>46410</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>White</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) _____					
18. FATHER'S NAME (First, Middle, Last) <b>Roy Patterson</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Green</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Marilyn C. Patterson</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7035 Carolina Pl. Merrillville, IN 46410</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) <b>October 29, 2004 Community Cremation Services</b>			21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>		
22a. EMBALMERS NAME <b>Alexis Thanos</b>		22b. EMBALMER'S LICENSE NO. <b>FD08600505</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Alexis Thanos</i>		24b. LICENSE NUMBER (of Licensee) <b>FD08600505</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, IN 46410</b>			
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— IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>a. Aortic Sinoatrial Block</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. CAD, Seizures</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last							
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) ----		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>A. Kawamleh</i>				29c. MEDICAL LICENSE NO. <b>01052395</b>		29d. DATE SIGNED (Month, Day, Year) <b>10/29/04</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Abdul Kawamleh, M.D., 8895 Broadway, Merrillville, Indiana 46410</b>							
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Bert, D.O.</i>				THIS CERTIFIES THE ABOVE IS A COMPLETE COPY OF THE CERTIFIED DEATH FILE WITH THE HEALTH OFFICE. <b>NOV 01 2004</b>			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)	
		34d. 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) <b>NOV 01 2004</b>			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)				34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

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FORMANT

POSITION

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