



SURVIVORSHIP AFFIDAVIT

81516  
STATE OF Indiana  
COUNTY OF Lake

} S. S.

Ret to Liberty Savings  
1900 Indianapolis Blvd  
Whiting, IN 46394

On this August 3, 2007 before me personally appeared  
(insert date)

Darlene L. Beerling

2007 095308

to me personally known, who being duly sworn on oath did say that:

- Affiant resides at the address given below affiant's signature;
- Affiant is owner  
(state interest of affiant in the above premises as "owner," "son of owner," etc.);
- Said premises were formerly owned as joint tenants or as tenants by the entireties by  
Charles W. Beerling and Darlene L. Beerling;
- Said Charles W. Beerling  
(fill in name of co-tenant who died)  
died on May 10, 2007  
leaving No will;  
(insert "a" or "no"; if will left, attach a copy)
- The legal description of the premises in question is:  
The North 20 feet of Lot 38, and the South 20 feet of Lot 39, Block 3, West Park, in the City of Hammond, as shown in plat book 12 page 35, in Lake County, IN commonly known as: 1917 Westpark Ave, Whiting, IN
- To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent;
- Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?  
No

(If answer is "Yes," identify the divorce proceedings:

8. Affiant's relationship to the deceased was Wife

"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."

Signature: Darlene L. Beerling

Address: 1917 Westpark Ave, Whiting, IN

PREPARED BY: Bgm

Subscribed and sworn to before me by the affiant

this August 3, 2007  
(insert date)

Paulina Grant  
Notary Public

My Commission Expires 12-17-08

FILED

DEC - 4 2007

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

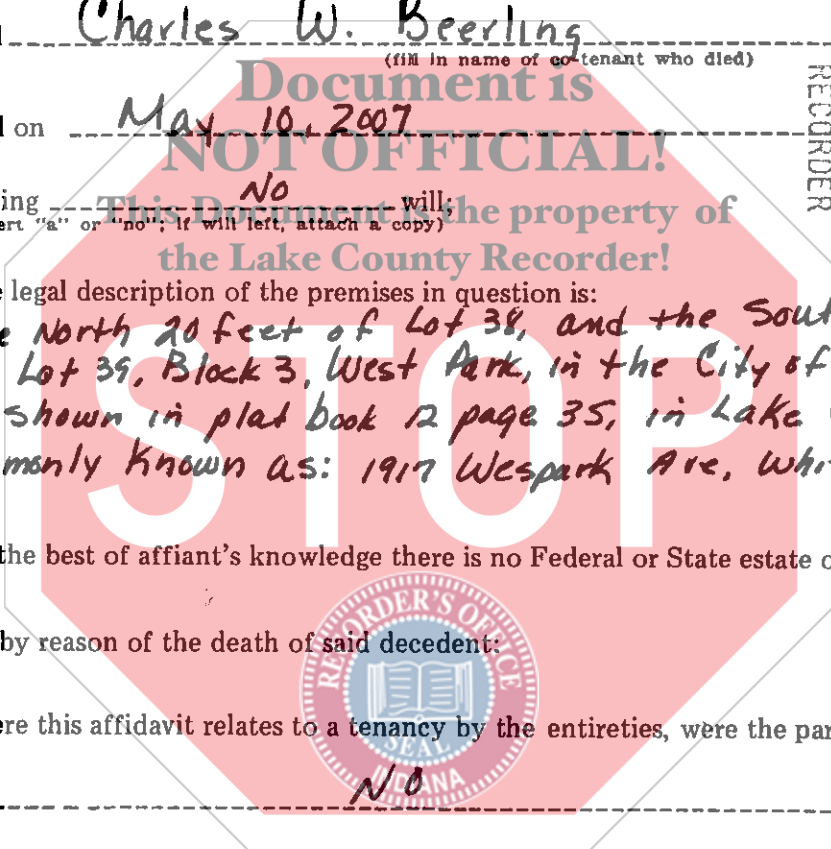
14<sup>00</sup>  
CT  
R

This instrument prepared by Darlene L. Beerling

CTIC has made an accommodation  
recording of the instrument

024043

Chicago Title Insurance Company



STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2007 DEC - 9 AM 9:21  
MICHAEL A. BROWN  
RECORDER

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to resume 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. 1211-07

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANTS

INFORMANT

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>CHARLES W. BEERLING</b>		2. SEX <b>MALE</b>	3a. TIME OF DEATH <b>10:48A.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>MAY 10, 2007</b>								
4. *SOCIAL SECURITY NUMBER <b>330-30-3485</b>	5a. AGE—Last Birthday (Years) <b>67</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>JULY 15, 1939</b>								
7. BIRTHPLACE (City and State or Foreign Country) <b>JOLIET, ILLINOIS</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>											
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence										
9b. FACILITY NAME (If not institution, give street and number) <b>WILLIAM J. RILEY MEMORIAL RESIDENCE</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>		9d. COUNTY OF DEATH <b>LAKE</b>								
10. MARITAL STATUS (Specify) <b>MARRIED</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>DARLENE L. WAGNER</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>COMMUNICATIONS ENGINEER/ CELWAVE/RES</b>		12b. KIND OF BUSINESS/INDUSTRY								
13a. RESIDENCE—STATE <b>INDIANA</b>	13b. COUNTY <b>LAKE</b>	13c. CITY, TOWN, OR LOCATION <b>HAMMOND(WHITING P.O.)</b>		13d. STREET AND NUMBER <b>1917 WESPARK AVENUE</b>								
13e. ZIP CODE <b>46394</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</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>5+</b> College (1-4 or 5+) <b>5+</b>		18. FATHER'S NAME (First, Middle, Last) <b>GEORGE BEERLING</b>										
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRANCES WRAY</b>		20a. INFORMANT'S NAME (Type/Print) <b>MRS. DARLENE L. BEERLING</b>										
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1917 WESPARK, WHITING, IN 46394</b>		20c. Relationship <b>WIFE</b>										
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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>MAY 15, 2007 HERITAGE CREMATORY</b>		21c. LOCATION—City or Town, State <b>PORTAGE, INDIANA</b>								
22a. EMBALMER'S NAME <b>HENRY J. BLAKE</b>		22b. EMBALMER'S LICENSE NO. <b>FDE01019406</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes								
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>FDE01019456</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BARAN &amp; SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394</b>								
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. <table border="1"> <tr> <td>IMMEDIATE CAUSE (This certificate of death on file with the county health department)</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE CAUSE OF DEATH ON FILE WITH THE COUNTY HEALTH DEPARTMENT <b>Colon Ca</b></td> <td><b>Months</b></td> </tr> <tr> <td>Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last</td> <td></td> </tr> <tr> <td><b>MAY 10 2007</b></td> <td></td> </tr> </table>					IMMEDIATE CAUSE (This certificate of death on file with the county health department)	Approximate Interval Between Onset and Death	THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE CAUSE OF DEATH ON FILE WITH THE COUNTY HEALTH DEPARTMENT <b>Colon Ca</b>	<b>Months</b>	Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		<b>MAY 10 2007</b>	
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<b>MAY 10 2007</b>												
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) <b>N/A</b>		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) <b>N/A</b>								
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>[Signature]</i>			29c. MEDICAL LICENSE NO. <b>01038072</b>	29d. DATE SIGNED (Month, Day, Year) <b>MAY 14, 2007</b>								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>ERWIN L. ROBIN, M.D., 801 MAC ARTHUR BLVD., MUNSTER, INDIANA 46321</b>												
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32. DATE FILED (Month, Day, Year) <b>MAY 15, 2007</b>								
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.												