

2



Survivorship Affidavit

2007 096739

State of Florida
County of Polk SS:

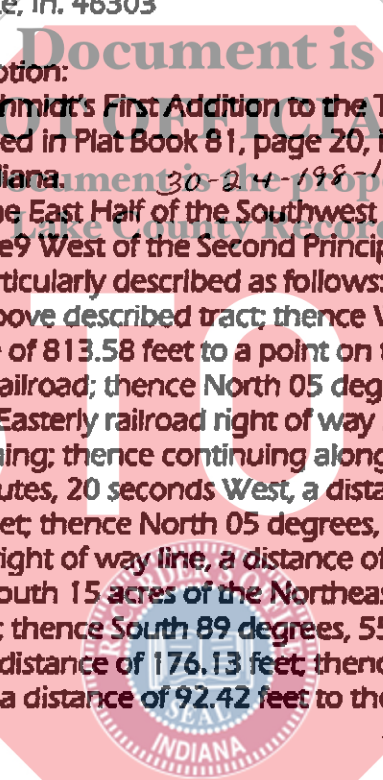
Laurence D. Parker, *being first duly sworn upon oath, deposes and says:
*aka Laurence Parker

- 1. That William R. Schmidt died (without leaving a will) (leaving a will)
6 on October 1999 at St. Anthony Medical Center
- 2. That William R. and Adeline T. were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
10608 W. 133rd Cedar Lake, In. 46303

Legal description:

Parcel 1: Lot 1 in Schmidt's First Addition to the Town of Cedar Lake, as per plat thereof, recorded in Plat Book 81, page 20, in the office of the recorder of Lake County, Indiana. 30-24-198-1

Parcel 2: being a part of the East Half of the Southwest Quarter of Section 21, Township 34 North, Range 9 West of the Second Principal Meridian, All in Lake County, Indiana, more particularly described as follows: Commencing at the Southeast corner of the above described tract; thence West along the South line of said Section 21, a distance of 813.58 feet to a point on the Easterly right of way line of the New York Central Railroad; thence North 05 degrees, 42 minutes, 20 seconds West, along said Easterly railroad right of way line, a distance of 834.16 feet to the point of beginning; thence continuing along said railroad right of way North 05 degrees, 42 minutes, 20 seconds West, a distance of 498.34 feet; thence East a distance of 15.00 feet; thence North 05 degrees, 42 minutes, 20 seconds West, along said Easterly right of way line, a distance of 494.60 feet to a point on the Northerly line of the South 15 acres of the Northeast Quarter of the Southwest Quarter of said section 21; thence South 89 degrees, 55 minutes, 44 seconds East along the aforesaid line a distance of 176.13 feet; thence South a distance of 987.80 feet; thence West, a distance of 92.42 feet to the point of beginning 30-24-5-89



2007 DEC 11 10:59 AM
FILED FOR RECORD
LAKE COUNTY
CLERK OF COUNTY

FILED
DEC 11 2007

- 3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the death of X (his) (her) death.
- 4. That all funeral expenses in connection with the death of said decedent have been paid in full.
- 5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

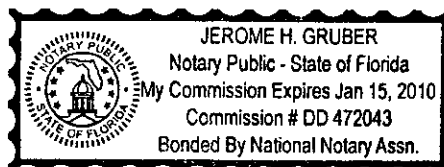
Laurence Parker Personal Rep
Laurence Parker aka Laurence D. Parker

Subscribed and sworn to before me, a Notary Public, this 24 day of March, 2007

Jerome H. Gruber
024323

My Commission expires: Jan 15, 2010
County of Residence: Polk

This instrument prepared by:



141975

* 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. 2317-99

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

268921
TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) WILLIAM R. SCHMIDT		2 SEX MALE	3a TIME OF DEATH 2:45P M	3b DATE OF DEATH (Month, Day, Year) OCTOBER 6, 1999
4 *SOCIAL SECURITY NUMBER 315-28-7208	5a AGE—Last Birthday (Years) 68	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) June 4, 1931
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IL	8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954	8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9a FACILITY NAME (If not institution, give street and number) St Anthony Medical Center		9b CITY, TOWN, OR LOCATION OF DEATH Crown Point	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Adeline Schmidt	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Clerk	12b KIND OF BUSINESS/INDUSTRY Railroad	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Cedar Lake	13d STREET AND NUMBER 10608 W. 133rd Avenue	
13e ZIP CODE 46303	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? 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
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (11-4 or 5+) 6		18 FATHER'S NAME (First, Middle, Last) Theodore Schmidt		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary Norris		20a INFORMANT'S NAME (Type/Print) Adeline Schmidt		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10608 W. 133rd Avenue, Cedar Lake, IN		20c Relationship Wife		
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) October 8, 1999 Calumet Park Crematory		21c LOCATION—City or Town, State Merrillville, IN
22a EMBALMER'S NAME William E. Burdan		22b EMBALMER'S LICENSE NO. FD01007697		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>William E. Burdan</i>		24b LICENSE NUMBER (of License) FD01007697		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burdan Funeral Home FH83002461 12901 Wicker, Cedar Lake, IN
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. Lung Cancer				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF) b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF)				
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) (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)
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 from 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>R. Drasga</i>			29c. MEDICAL IDENTIFICATION NUMBER 01031464	29d. DATE SIGNED (Month, Day, Year) Oct 13, 1999
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (MEM 26) (Type/Print) Ray DRASGA, 8127 Merrillville Rd, Merrillville, IN 46410				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Hollins</i> MD			32. DATE FILED (Month, Day, Year) October 13, 1999	
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)		34e DESCRIBE HOW INJURY OCCURRED THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT		
34f LOCATION (Street and Number or Rural Route Number, City or Town, State) NOV 09 2007 024524		34g DATE PRONOUNCED DEAD (Month, Day, Year)		
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.				

DECEDENT

PARENTS

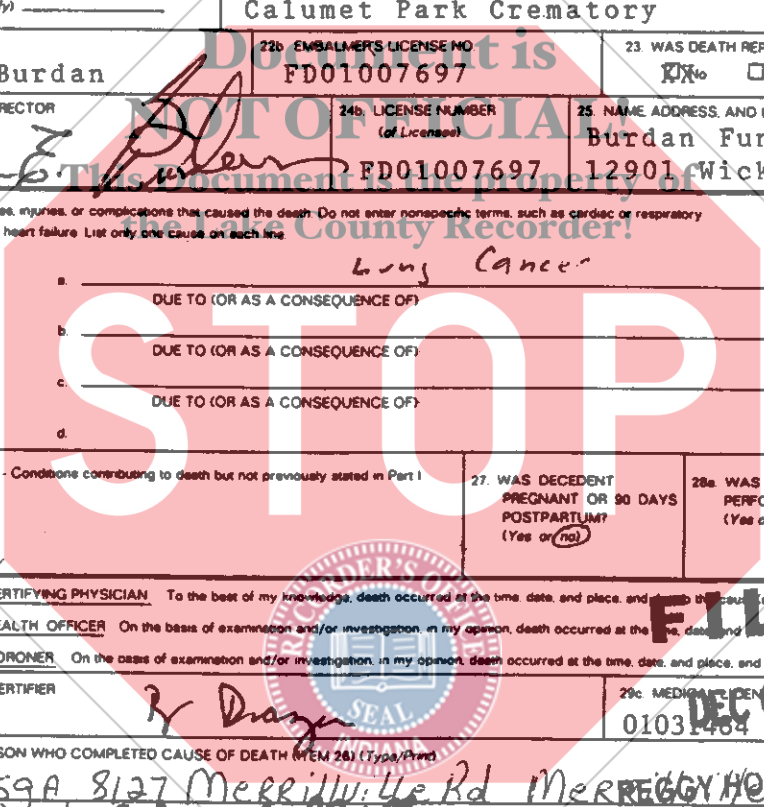
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



FILED