

M

2007 097590

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2007 DEC 13 AM 9:22  
MICHAEL A. BROWN  
RECORDER

AT 711197

 **Chicago Title Insurance Company**  
SURVIVORSHIP AFFIDAVIT

On this 12/06/2007 before me personally appeared THELMA MILLER  
(insert date)

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

CHICAGO TITLE INSURANCE COMPANY

- 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 CLAUDE V MILLER and THELMA MILLER;

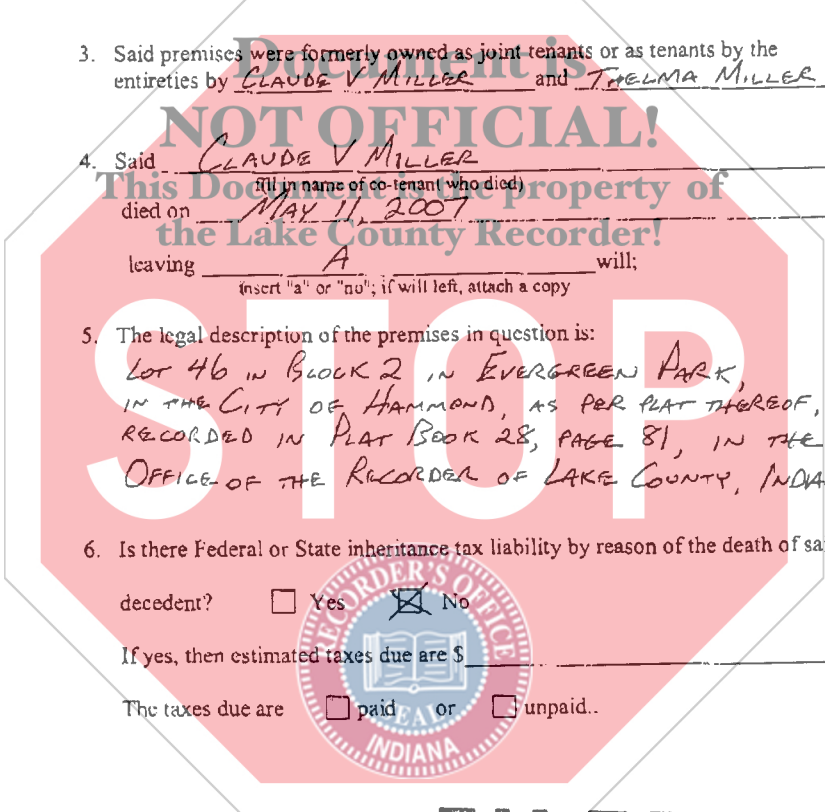
4. Said CLAUDE V MILLER  
(fill in name of co-tenant who died)  
died on MAY 11, 2007  
leaving A will;  
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:  
LOT 46 IN BLOCK 2 IN EVERGREEN PARK,  
IN THE CITY OF HAMMOND, AS PER PLAT THEREOF,  
RECORDED IN PLAT BOOK 28, PAGE 81, IN THE  
OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent?  Yes  No

If yes, then estimated taxes due are \$ \_\_\_\_\_

The taxes due are  paid, or  unpaid.



**FILED**

DEC 12 2007

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

12/6/07  
S. J. D.

024385

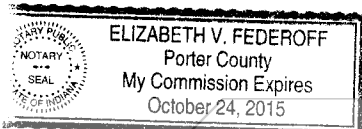
①

7. 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 SPOUSE



Signature: Thelma Miller

Printed Name THELMA MILLER

Address: 7622 BIRCH AVE

HAMMOND, IN 46324

Subscribed and sworn to before me by the affiant

This 12/6/07  
(insert date)

**Document is NOT OFFICIAL!**  
**This Document is the property of the Lake County Recorder!**

Elizabeth V. Federoff  
Notary Public

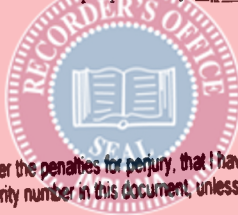
Printed Name Elizabeth V. Federoff

My County of Residence is: Porter

In the State of IN

My Commission Expires 10/24/15

This instrument prepared by Thelma Miller



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. Vaun Federoff

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. 1193-07

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

|   |   |   |   |   |   |  |  |
|---|---|---|---|---|---|--|--|
| 1 DECEASED—NAME (First, Middle, Last)<br>Claude V. Miller   |   |   |   | 2 SEX<br>Male   | 3a TIME OF DEATH<br>8:55P M   | 3b DATE OF DEATH (Month, Day, Yr.)<br>May 11, 2007   |  |
| 4 *SOCIAL SECURITY NUMBER<br>[REDACTED]-8511  | 5a AGE—Last Birthday (Years)<br>89  | 5b UNDER 1 YEAR<br>Months Days  | 5c UNDER 1 DAY<br>Hours Minutes   | 6 DATE OF BIRTH (Mo, Day, Yr.)<br>November 7, 1917  | 7 BIRTHPLACE (City and State or Foreign Country)<br>Alder Springs, TN |  |  |
| 8a WAS DECEDENT A U.S. VETERAN?<br>Yes  | 8b YEAR LAST SERVED IN U.S. ARMED FORCES?<br>1945   | 9a PLACE OF DEATH (Check only one See instructions)<br>HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Residence |   | 9b FACILITY NAME (If not institution, give street and number)<br>Munster Med-Inn  |   |  |  |
| 10 MARITAL STATUS (Specify)<br>Married  |   |   | 11 SURVIVING SPOUSE (If wife, give maiden name)<br>Thelma B. Lovely   | 12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br>Millwright  | 12b KIND OF BUSINESS/INDUSTRY<br>Steel                                |  |  |
| 13a RESIDENCE—STATE<br>Indiana  |   | 13b COUNTY<br>Lake  | 13c CITY, TOWN, OR LOCATION<br>Hammond  |   | 13d STREET AND NUMBER<br>7622 Birch Ave.                              |  |  |
| 13e ZIP CODE<br>46324   | 13f INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 13g ON A FARM?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes   | 14 CITIZEN OF WHAT COUNTRY?<br>USA  | 15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | 16 RACE—American Indian, Black, White, etc (Specify)<br>White         | 17 DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/><br>5 |  |
| 18 FATHER'S NAME (First, Middle, Last)<br>Pryor Miller  |   |   |   | 19 MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Wilson  |   |  |  |
| 20a INFORMANT'S NAME (Type/Print)<br>Thelma B. Miller   |   |   | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7622 Birch Ave. Hammond, IN 46324 |   | 20c Relationship<br>wife  |  |  |
| 21a METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <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)<br>May 17, 2007<br>Chapel Lawn Memorial Gardens   |   | 21c LOCATION—City or Town, State<br>Scherverville, Indiana  |   |  |  |
| 22a EMBALMER'S NAME<br>David R. Peterson  |   |   | 22b EMBALMER'S LICENSE NO.<br>FD08601585  | 23 WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  |   |  |  |
| 24a SIGNATURE OF FUNERAL DIRECTOR<br>C.A. Kuiper  |   | 24b LICENSE NUMBER (of Licensee)<br>FD01014511  |   | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br>Kuiper Funeral Home 9039 Kleinman Rd. Highland IN 46322 FH10300021                                      |   |  |  |
| 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.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death)<br>a. <u>urosepsis</u><br>DUE TO (OR AS A CONSEQUENCE OF)<br>b. _____<br>DUE TO (OR AS A CONSEQUENCE OF)<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF)<br>d. _____<br><br>Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last   |   |   |   |   |   | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I<br><u>end stage dementia</u>   |   |   |   | 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)<br>NO   | 28a WAS AN AUTOPSY PERFORMED? (Yes or no)<br>NO                       | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)<br>NO   |  |
| 29a CERTIFIER (Check only one)<br><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<br><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<br><input checked="" 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<br><i>[Signature]</i>  |   |   |   | 29c MEDICAL LICENSE NO.<br>01052047   | 29d DATE SIGNED (Month, Day, Year)<br>5/14/07                         |  |  |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br>Dr. Josecito Navarro 7905 Calumet Ave, Munster, IN 46321   |   |   |   |   |   |  |  |
| 31 HEALTH OFFICER'S SIGNATURE<br><i>[Signature]</i>   |   |   |   |   | 32 DATE FILED (Month, Day, Year)<br>May 14, 2007                      |  |  |
| 33 MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined<br><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.                                       |   |   |  |  |