STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2007 DEC 13 AM 9:22

MICHAEL A. BROWN
RECORDER

2007 097590

AT 711197

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

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

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

1. Affiant resides at the address given below affiant's signature:

2. Affiant is OWNER (state interest of affiant in the above premises as "owner," son of owner", etc.

3. 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 (insert "a" or "no"; if will left, attach a copy) will;

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..

CHICAGO TITLE INSURANCE COMPANY

FILED

DEC 12 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

024385

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

ELIZABETH V. FEDEROFF
Porter County
My Commission Expires
October 24, 2015

Subscribed and sworn to before me by the affiant

This 12/6/07
(insert date)

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

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.

Local No. 1193-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): Claude V. Miller
2 SEX: Male
3a TIME OF DEATH: 8:55P M
3b DATE OF DEATH (Month, Day, Yr.): May 11, 2007
4 *SOCIAL SECURITY NUMBER: [redacted]-8511
5a AGE—Last Birthday (Years): 89
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day. Yr.): November7,1917
7 BIRTHPLACE (City and State or Foreign Country): Alder Springs,TN
8a WAS DECEDENT A U.S. VETERAN?: Yes
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence
9b FACILITY NAME (If not institution, give street and number): Munster Med-Inn
9c CITY, TOWN, OR LOCATION OF DEATH: Munster
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): Thelma B. Lovely
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Millwright
12b KIND OF BUSINESS/INDUSTRY: Steel
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN, OR LOCATION: Hammond
13d STREET AND NUMBER: 7622 Birch Ave.
13e ZIP CODE: 46324
13f INSIDE CITY LIMITS ☐ No ☒ Yes
13g ON A FARM? ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 5; College (1-4 or 5 +):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Pryor Miller
19 MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Wilson

INFORMANT

20a INFORMANT'S NAME (Type/Print): Thelma B. Miller
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7622 Birch Ave.Hammond,IN 46324
20c Relationship: wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify) _____
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 17, 2007 Chapel Lawn Memorial Gardens
21c LOCATION—City or Town, State: Schererville, Indiana
22a EMBALMER'S NAME: David R. Peterson
22b EMBALMER'S LICENSE NO.: FD08601585
23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: C.A Kuiper
24b LICENSE NUMBER (of Licensee): FD01014511
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland,IN 46322 FH10300021

CAUSE OF DEATH

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. urosepsis
DUE TO (OR AS A CONSEQUENCE OF)
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

Approximate Interval Between Onset and Death

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: end stage Dementia

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

CERTIFIER

29a CERTIFIER (Check only one)
☒ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c MEDICAL LICENSE NO: 01052047
29d DATE SIGNED (Month, Day, Year): 5/14/07
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Joselito Navarro 7905 Calumet Ave. Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] D.O.
32 DATE FILED (Month, Day, Year): May 14, 2007

33 MANNER OF DEATH: ☐ 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.

SDH06-004 State Form 10110 (R5/1-99)