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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2007 097662

2007 DEC 13 AM 10:36

State of: Indiana
County of: Lake

MICHAEL A. BROWN
RECORDER

SURVIVORSHIP AFFIDAVIT

Raean M. Human (hereinafter referred to as "Affiant"), being first duly sworn upon oath, deposes and says:

That Affiant is the owner in fee simple of the following described real estate, located in Lake County, State of Indiana, described as follows, to-wit:

The South half of Lot 21, Block 2 in Westwood, as per plat thereof, recorded in Plat Book 73, page 32, in the Office of the Recorder of Lake County, Indiana.

8-15-0617-0021

and that Affiant and Affiant's now deceased spouse, **L. Dale Human** were husband and wife at the time they acquired title to said real estate as tenants by the entireties; that the marital relationship which existed between said Affiant and Affiant's now deceased spouse continued unbroken from the time that they acquired title to said real estate until the death of Affiant's spouse on 8/3/2005 at which time Affiant acquired title to said real estate as surviving tenant by the entirety.

That the gross value of the estate of Affiant's deceased spouse, including interest in jointly held property, the proceeds of life insurance, gifts in contemplation of death, and all other assets, did not exceed the exemption to which Affiant's deceased spouse's estate was entitled, as a consequence of which the estate of Affiant's deceased spouse was not subject to Federal Estate Tax; further, that there is not unpaid Indiana Inheritance Tax on the estate of Affiant's deceased spouse or upon the said real estate.

Further Affiant saith not.



Raean M. Human
Raean M. Human

Subscribed and sworn to before me, a Notary Public, in and for said County and State, this 11/28/2007.



Diane M. Capiak
Diane M. Capiak

My Commission Expires: 4/23/2014

Residing in Lake

This instrument prepared by: Wendy S. Gibbons, Attorney at Law 16726-53

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. Diane Capiak
File Number: 760002120

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DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER

DEC 13 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

024432

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to determine its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Key # 8-15-2007 0021

CERTIFICATE OF DEATH

Local No. 2026-05

State No.

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

79577
PE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First, Middle, Last) Luther Dale Human				2 SEX Male	3a TIME OF DEATH 12:00p	3b DATE OF DEATH (Month, Day, Yr.) August 3, 2005	
4 *SOCIAL SECURITY NUMBER 304-36-6386	5a AGE—Last Birthday (Years) 71	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Jan. 18, 1934	7 BIRTHPLACE (City and State or Foreign Country) Gas City, Ind.		
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1955	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" 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) Methodist Southlake Campus			9c CITY, TOWN, OR LOCATION OF DEATH Merrillville	9d COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) RaeAn Paris	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Police Officer		12b KIND OF BUSINESS/INDUSTRY City of Gary			
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Merrillville		13d STREET AND NUMBER 8773 Van Buren St.			
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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 (1-4 or 5+) 		
18 FATHER'S NAME (First, Middle, Last) Luther Human			19 MOTHER'S NAME (First, Middle, Maiden Surname) Juanita Stevens				
20a INFORMANT'S NAME (Type/Print) RaeAn Human		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8773 Van Buren St. M'ville, In			20c Relationship wife		
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) August 5, 2005 Calumet Park Cemetery			21c LOCATION—City or Town, State Merrillville, Indiana		
22a EMBALMER'S NAME N/A		22b EMBALMER'S LICENSE NO. N/A		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony J. Rendina</i>		24b LICENSE NUMBER (of Licensee) FD01010402	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rendina Funeral Home FH83007819 5100 Cleveland St. Gary, 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cardiorespiratory arrest DUE TO (OR AS A CONSEQUENCE OF) b. Probable Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.				Approximate Interval Between Onset and Death Minutes Minutes			
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Onophryzed Concussion		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 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>Michael Kovach MD</i>		29c MEDICAL LICENSE NO. 01033371 A	29d DATE SIGNED (Month, Day, Year) 8.4.05		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Michael Kovach MD 8777 Broadway Merrillville, In. 46410							
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best D.O.</i>					32 DATE FILED (Month, Day, Year) August 4, 2005		
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.					

DECEDENT

RENTS

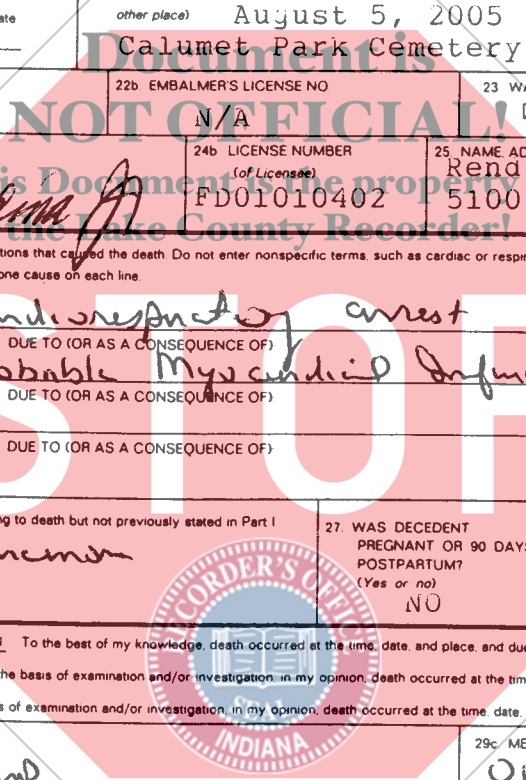
FORMANT

POSITION

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