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SURVIVORSHIP AFFIDAVIT

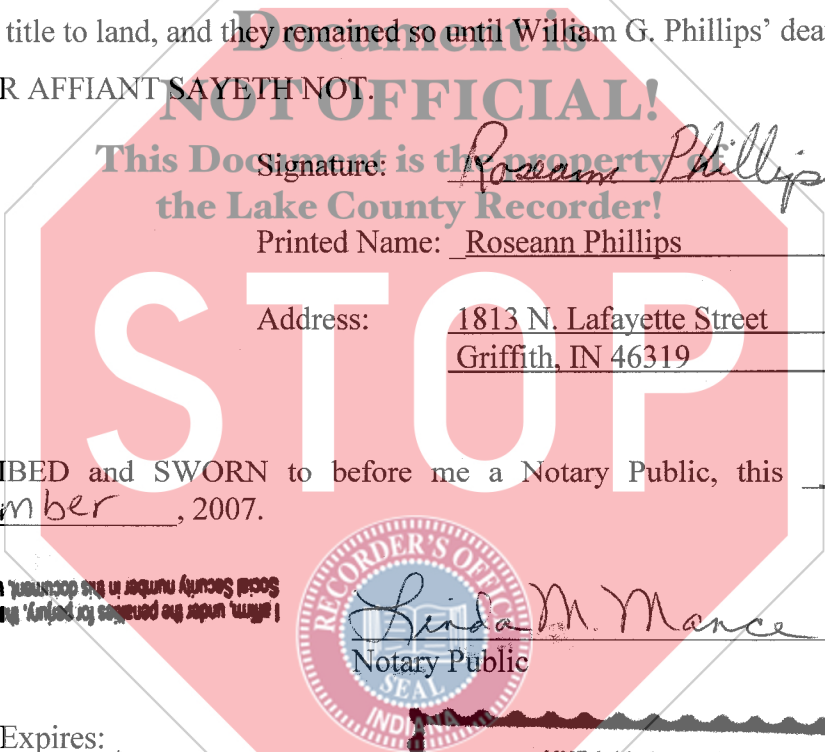
On this 5th day of November, 2007, before me personally appeared ROSEANN PHILLIPS, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is owner of said premises;
3. Said premises were formerly owned as joint tenants or as tenants by the entirety by William G. Phillips and Roseann Phillips;
4. Said William G. Phillips died on June 6, 2007;
5. The legal description of the premises in question is:

Lot 10, Block 2, Bellamy and Gage North Ridge Estates 1st Addition, to the Town of Griffith, as shown in Plat Book 35, Page 74, in the Office of the Recorder of Lake County, Indiana.

6. That Affiant, Roseann Phillips, and William G. Phillips were husband and wife at the time of acquiring title to land, and they remained so until William G. Phillips' death.

FURTHER AFFIANT SAYETH NOT.



2007 09 9 5 52

2007 DEC 20 AM 9:29

MICHAEL A. BROWN
RECORDER

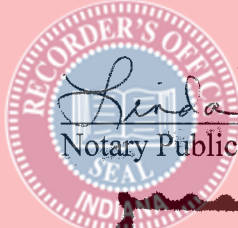
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

Signature: Roseann Phillips
Printed Name: Roseann Phillips

Address: 1813 N. Lafayette Street
Griffith, IN 46319

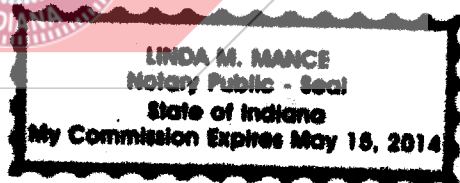
SUBSCRIBED and SWORN to before me a Notary Public, this 5th day of November, 2007.

I affirm, under the penalties for perjury, that I have taken reasonable care to read each Social Security number in this document, unless required by law. Kevin Zambra



Linda M. Mance
Notary Public

My Commission Expires: _____
My County of Residence: Lake



FILED

DEC 19 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Handwritten initials: H, D, C

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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to insure 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. 1433-07

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED-NAME (First, Middle, Last) William G. Phillips				2. SEX Male	3a. TIME OF DEATH 11:54	3b. DATE OF DEATH (Month, Day, Yr) June 6, 2007
4. *SOCIAL SECURITY NUMBER 308-36-██████	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) June 25, 1935	7. BIRTHPLACE (City and State or foreign Country) Hammond, Indiana	
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1957	9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence Hospice				
9b. FACILITY NAME (If not institution, give street and number) 1813 N. LaFayette			9c. CITY, TOWN OR LOCATION OF DEATH Griffith	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Rosann Kovacic	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Foreman		12b. KIND OF BUSINESS/ INDUSTRY Steel Company		
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Griffith		13d. STREET AND NUMBER 1813 N. LaFayette		
13e. ZIP CODE 46319	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) James W. Phillips			19. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve Myers			
20a. INFORMANT'S NAME (Type/Print) Rosann Phillips		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 N. LaFayette Griffith, IN 46319		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) June 11, 2007 Oakland Memory Lanes		21c. LOCATION - City or Town, State Dolton, Illinois		
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>David A. Gabach</i>		24b. LICENSE NUMBER (of Licensee) FD20500014		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Chapel Lawn Funeral Home FH19900051 8178 Gline Ave. Schererville, IN 46375		
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) Conditions, if any, which gave rise to the immediate cause, starting the underlying cause last		a. ACUTE MYELOGENAL LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): b. NON-HODGKINS LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____				Approximate Interval Between Onset and Death
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) NO
29a. CERTIFIER (Check only one) <input 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>Charles D. Egnatz</i>				29c. MEDICAL LICENSE NO. 0209054	29d. DATE SIGNED (Month, Day, Year) 6-7-07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. EGNATZ - 1326 W. US 30 Schererville, IN 46375						
31. HEALTH OFFICER'S SIGNATURE <i>Susan J. Burt</i>						
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. DESCRIBE HOW INJURY OCCURRED June 6, 2007	
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.				