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STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

Comes now Jody King, and upon being duly sworn does attest and say:

1. That the affiant is the Daughter of Lilian J. Kellen, deceased.

2. That Lilian J. Kellen held an interest in the real property located in Lake County, Indiana, more particularly described as:

   ALL OF LOT 5, BLOCK 14, COUNTRY CLUB ESTATES SUBDIVISION, AS RECORDED IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

   GRAN TEE ADDRESS

   Commonly known as: 1217 W. 44th Place, Hobart, IN 46342

3. That Lilian J. Kellen died on the 14th day of May, 2006.

4. That this Affidavit is made to induce the Assessor of Lake County and the Recorder of Lake County to remove the name of Lilian J. Kellen from this record.

5. That Jody King will hold the Lake County Assessor and the Lake County Recorder harmless for their reliance on this Affidavit.

I affirm under the penalties for perjury that the foregoing statements are true.

Jody King

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DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

SEP 05 2008

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

015614

#9800 15 B3

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Subscribed and sworn to before me this 20 day of August, 2008.

My Commission
03/25/2010

Patricia A. Rees, Notary Public
Resident of Lake County, Indiana

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

Patricia A. Rees

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the Lake County Recorder!
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RECORDER'S OFFICE SEAL INDIANA

This Instrument Prepared by: Patricia A. Rees, Attorney at Law, 5341 Central Ave., Portage, IN 46368 (219) 947-1692.

10 CCS

* 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. 1201-06

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): LILIAN JOAN KELLEN
2. SEX: Female
3a. TIME OF DEATH: 9:55 PM
3b. DATE OF DEATH (Month, Day, Yr.): May 14, 2006
4. *SOCIAL SECURITY NUMBER: 311-44-9998
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): May 14, 1937
7. BIRTHPLACE (City and State or Foreign Country): Stockport England
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): James Kellen
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Floral Designer
12b. KIND OF BUSINESS/INDUSTRY: Florist
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 1217 W. 44th Place
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] 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): 12; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): J. Richard Barnes
19. MOTHER'S NAME (First, Middle, Maiden Surname): Lilian Halls

INFORMANT

20a. INFORMANT'S NAME (Type/Print): James Kellen
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1217 W. 44th Place, Hobart, IN 46342
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [ ] Entombment [ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 19, 2006 Calvary Crematory
21c. LOCATION—City or Town, State: Portage IN
22a. EMBALMER'S NAME: James J. Krause
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James J Krause
24b. LICENSE NUMBER (of Licensee): FD01006463
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Rees Funeral Home, Inc. FH83003069, 600 W. Old Ridge Road, Hobart, IN 46342-0488

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. Begin with the immediate cause, then, on each line, state the condition resulting in the immediate cause, and so on. Leave blank if unknown.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. non small cell carcinoma of lung — Approximate Interval Between Onset and Death: one year

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

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: arteriosclerotic heart disease, myocardial infarction

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):
[X] 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: Donald M Phillips MD
29c. MEDICAL LICENSE NO.: 01020846
29d. DATE SIGNED (Month, Day, Year): April 17, 2006
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Donald M Phillips MD 1356 S. Lake Park Avenue, Hobart, IN 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.
32. DATE FILED (Month, Day, Year): May 18, 2006

33. MANNER OF DEATH: [X] 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.

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THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.
APR 20 2007

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