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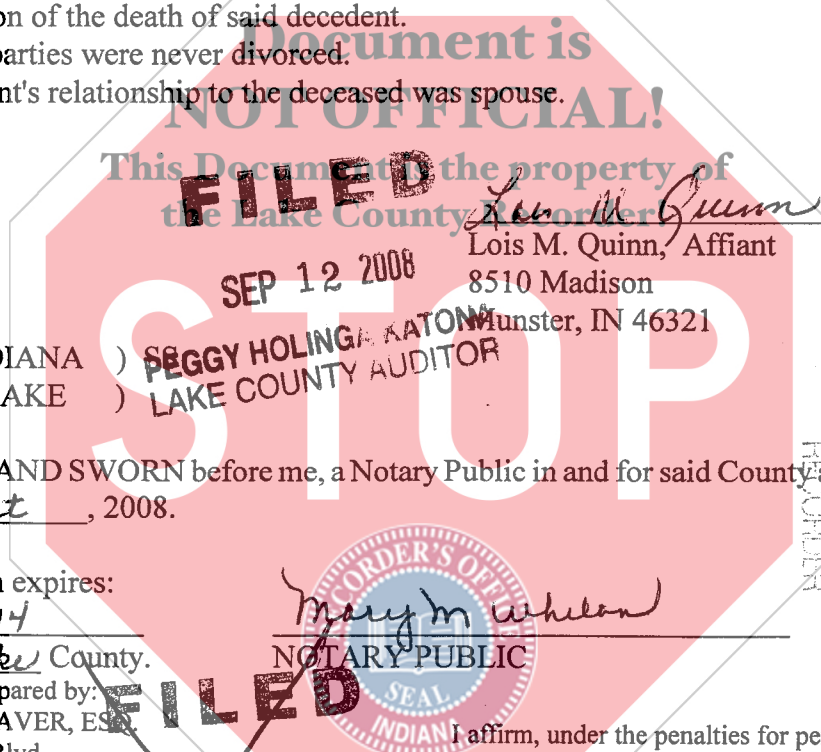
AFFIDAVIT OF SURVIVORSHIP

ON THIS 11 DAY OF August, 2008, personally appeared Lois M. Quinn, the affiant, who being duly sworn her upon oath, did say that:

1. Affiant resides at the address given below Affiant's signature;
2. Affiant is joint owner of the premises located at 8510 Madison, Munster, Indiana, and described below;
3. Said premises were formerly owned as tenants by the entireties by Patrick T. Quinn and Lois M. Quinn, husband and wife.
4. Said Patrick T. Quinn died intestate on the 20th day of February, 2005.
5. The legal description of the said premises in question is:

Lot Two (2), Block One (1), Rueth Estates First (1st) Addition to the Town of Munster, Lake County, Indiana, as shown in Plat Book 46, Page 21. Key No. 28-400-2

6. To the best of affiant's knowledge, there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent.
7. The parties were never divorced.
8. Affiant's relationship to the deceased was spouse.



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2008 SEP 15 AM 8:56

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDER

MICHAEL A. BOOM
RECORDER

STATE OF INDIANA)
COUNTY OF LAKE)

PEGGY HOLINGA-KATONA
LAKE COUNTY AUDITOR

SUBSCRIBED AND SWORN before me, a Notary Public in and for said County and State, this day of August, 2008.

My Commission expires:
11-28-2014

Mary M. Whelan
NOTARY PUBLIC

Resident of Lake County.
This instrument prepared by:
BARBARA M. SHAVER, ESQ.
9013 Indianapolis Blvd.
Highland, IN 46322
219/838-9200

FILED
SEP 04 2008

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.

Barbara M. Shaver

PEGGY HOLINGA-KATONA
LAKE COUNTY AUDITOR

CHK# 3116
14.02
B
W

~~2008~~

Local No. 567-05

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

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Ratrick T. Quinn				2. SEX Male	3a. TIME OF DEATH 4:00 A.M.	3b. DATE OF DEATH (Month, Day, Yr.) Feb. 20, 2005	
4. *SOCIAL SECURITY NUMBER 342-12-0809		5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) Sept. 22, 1923	7. BIRTHPLACE (City and State or Foreign Country) Chicago, IL.	
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1951		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			
9b. FACILITY NAME (If not institution, give street and number) 8510 Madison Ave				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) Lois Hawley		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Electrician		12b. KIND OF BUSINESS/INDUSTRY NIPSCO	
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Munster		13d. STREET AND NUMBER 8510 Madison Ave	
13e. ZIP CODE 46321		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input 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) William Quinn				19. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Connolly			
20a. INFORMANT'S NAME (Type/Print) Lois Quinn				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8510 Madison Munster, IN46321		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" 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) Feb. 24, 2005 Assumption Cemetery			21c. LOCATION—City or Town, State Glenwood, IL.	
22a. EMBALMER'S NAME John Noble			22b. EMBALMER'S LICENSE NO. 9000031		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>			24b. LICENSE NUMBER (of Licensee) 1021590		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home 3004966 8415 Calumet Munster, IN46321		
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. Congestive Heart Failure				Approximate Interval Between Onset and Death 5 years	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. Aortic Valve Disease				5 years	
		c. _____					
		d. _____					
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) NA		
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>[Signature]</i>				29c. MEDICAL LICENSE NO. 1029887		29d. DATE SIGNED (Month, Day, Year) 2/2	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. A. Gandhi 9126 Columbia Ave. Munster, IN 46321							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32. DATE FILED (Month, Day, Year) February 25, 2005		
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 THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.		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) FEB 25 2005	
34g. DATE PRONOUNCED DEAD (Month, Day, Year)			34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				