2

# TICOR TITLE INSURANCE

## AFFIDAVIT

2008 0645771

STATE OF INDIANA )
) SS:
COUNTY OF LAKE )

LOLA M VANBLACK, being first duly

Sworn upon oath, deposes and says:

2008 SEP 15 AM 9:27
MICHAEL A. BROWN
RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

1. That ROBERT R VANBLACK
died on JANUARY 1, 2005, at 3:31AM

2. That ROBERT R VANBLACK and LOLA M VANBLACK
were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 7 IN HOMEWOOD SUBDIVISION, IN THE CITY OF HOBART, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 21 PAGE 12, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

45-09-30-377-007.000-018



3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of his/her death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

FILED
SEP 11 2008
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

5. That all of the assets of said decedent which would be includable in Federal Estate tax purposes, including joint bank accounts and life insurance on decedent's life were Not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Lola M. VanBlack by Veronica Gearhart
as Attorney in-fact
LOLA M. VANBLACK BY VERONICA GEARHART
AS ATTORNEY IN-FACT POA Doc# 2008-0164576

Subscribed and sworn to before me, a Notary Public, this 5TH day of SEPTEMBER, 2008.

Notary Public: STACI MARIE FINCH

My commission expires: 2/20/2008

County of Residence: LAKE 014997

STACI MARIE FINCH
Lake County
My Commission Expires
Feb. 20, 2016

This Instrument prepared by: LOLA M. VANBLACK BY VERONICA GEARHART AS ATTY. INFACT

15-T55

TICOR TITLE - HOBART 920085109

6CC'S+2ULT

* **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.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Local No. 0014-05 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): ROBERT R. VanBLACK
2. SEX: Male
3a. TIME OF DEATH: 3:31 AM M
3b. DATE OF DEATH (Month, Day, Yr.): January 1, 2005
4. *SOCIAL SECURITY NUMBER: 722-12-8609
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo. Day. Yr.): January 26, 1927
7. BIRTHPLACE (City and State or Foreign Country): Gary Indiana
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1947
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): Lola Garrett
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance
12b. KIND OF BUSINESS/INDUSTRY: Oil Refinery
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hobart
13d. STREET AND NUMBER: 137 N. Delaware Street
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): Russell VanBlack
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Kurts

**INFORMANT**

20a. INFORMANT'S NAME (Type/Print): Lola VanBlack
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 137 N. Delaware Street, Hobart, IN 46342
20c. Relationship: Wife

**DISPOSITION**

21a. METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Jan 5, 2005 McCool Cemetery
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. Use only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Resp failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Septic Shock
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:
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:
29c. MEDICAL LICENSE NO.: 0105547A
29d. DATE SIGNED (Month, Day, Year): 1-5-05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Kais Yehyawi MD 8895 Broadway, Merrillville, IN 46410

**HEALTH OFFICER**

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): January 6, 2005

33. MANNER OF DEATH: [X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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.

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