Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

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RT810121

2008 079527

CHICAGO TITLE INSURANCE COMPANY

On this 11/14/08 (insert date) before me personally appeared Bethy M. Hinkel

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is Owner (state interest of affiant in the above premises as "owner"," son of owner", etc.

2008 NOV 21 AM 9:13

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by husband and wife;

4. Said Ralph H. Hinkel (fill in name of co-tenant who died) died on _____ leaving _____ will; (insert "a" or "no"; if will left, attach a copy

5. The legal description of the premises in question is:

LOT 3 AND THE WEST 18 FEET OF LOT 4 IN BLOCK 8 IN THE ORIGINAL TOWN OF DYER, AS PER PLAT THEREOF, RECORDED IN MISCELLANEOUS RECORD "A" PAGE 251 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☒ No

If yes, then estimated taxes due are $ _____

The taxes due are ☐ paid or ☐ unpaid..

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LP
CT

FILED

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PEGGY [illegible]
LAKE COUNTY AUDITOR

017986

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? No

(If answer is "Yes" , identify the divorce proceedings:

_____):

8. Affiant's relationship to the deceased was wife

Signature: x Betty M Hinkel

Printed Name Betty M. Hinkel

Address: 12151 W. 83rd Place

St. John, IN 46373

Subscribed and sworn to before me by the affiant

This 11/14/08
(insert date)

_____
Notary Public

Printed Name Elizabeth V. Federoff

My County of Residence is: Porter

In the State of IN

My Commission Expires 10/24/15

This instrument prepared by BETTY M. HINKEL

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. Vaun Federoff

* 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. 849

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Dec 21, 2004 Date Issued — Hammond Health Commissioner

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): RALPH HENRY HINKEL
2. SEX: MALE
3a. TIME OF DEATH: 8:08 AM
3b. DATE OF DEATH (Month, Day, Yr.): DECEMBER 20, 2004
4. *SOCIAL SECURITY NUMBER: 345-20-6290
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 6, 1927
7. BIRTHPLACE (City and State or Foreign Country): CHICAGO, ILLINOIS
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): [X] HOSPITAL Inpatient; [ ] ER/Outpatient; [ ] DOA; [ ] OTHER Nursing Home; [ ] Other (Specify); [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): SELECT SPECIALTY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): BETTY KJEKDSEN
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): PLUMBER
12b. KIND OF BUSINESS/INDUSTRY: DISNEYLAND
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: DYER
13d. STREET AND NUMBER: 216 ILLINOIS STREET
13e. ZIP CODE: 46311
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): JACOB T. HINKEL
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE L. FLANAGAN

INFORMANT

20a. INFORMANT'S NAME (Type/Print): BETTY HINKEL
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 ILLINOIS ST. DYER, IN 46311
20c. Relationship: WIFE

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): DECEMBER 22, 2004 NORTHWEST INDIANA CREMATION SERVICES
21c. LOCATION—City or Town, State: CROWN POINT, INDIANA
22a. EMBALMER'S NAME: NOT EMBALMED
22b. EMBALMER'S LICENSE NO.: N/A
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Rick Miller
24b. LICENSE NUMBER (of Licensee): FD20400030
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH83001504 FAGEN-MILLER FUNERAL HOME 1920 HART ST. DYER, IN 46311

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. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. C.O.P.D — Approximate Interval Between Onset and Death:
DUE TO (OR AS A CONSEQUENCE OF):
b. Pneumonia
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: 01030518A
29d. DATE SIGNED (Month, Day, Year): DECEMBER 21, 2004

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): SOMPOP SRISUWANANUKORN, M.D. 505 W. LINCOLN HIGHWAY SCHERERVILLE, INDIANA 46375
31. HEALTH OFFICER'S SIGNATURE: R R Ramana MD
32. DATE FILED (Month, Day, Year): December 21, 2004

33. MANNER OF DEATH: [ ] 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.