4

HEIRSHIP AFFIDAVIT

2009 021900

The undersigned being first duly sworn upon their oath states:

1. That Cecil W. Larson and Patricia J. Larson were the owners of the following described parcel of real estate:

   Lots 45 and 46, Block 26, in Manufacturer's Addition to Hammond as per plat thereof, recorded in Plat Book 2 page 24 in the Office of the Recorder of Lake County, Indiana.

2. That Cecil W. Larson died on the 21 day of March, 1999 and on the date of his death he was still married to Patricia J. Larson.

3. That Patricia J. Larson died on the 29 day of June, 2006 a resident of Lake County, Indiana.

4. That on the date of death of Patricia J. Larson, she was survived by three children, namely, Terri Ann Larson-Holt, James Larson and John Larson.

5. That Patricia J. Larson had one other child, namely, Thomas Larson, who predeceased her; however, he had no children. WAS NEVER MARRIED

6. That there has been no estate opened for Patricia J. Larson nor is there one contemplated, however, Patricia J. Larson did leave a Last Will and Testament ultimately devising the entire residue of her estate to a Revocable Living Trust with John Larson as Trustee.

7. That the trust was set up for the primary benefit of Cecil W. Larson who predeceased Patricia and that the beneficiaries of the trust after Cecil W. Larson were the three living children of Patricia, namely, Terri Ann Larson-Holt, James Larson and John Larson.

8. There are no State or Federal Inheritance or State taxes due and owing by the reason of the death of Patricia J. Larson, nor are there any unpaid bills or claims against Patricia Larson.

9. Your affiant makes this affidavit in order to induce the Lake County Auditor to transfer the property into the names of Terri Ann Larson-Holt, James Larson and John Larson.

FURTHER AFFIANT SAITH NOT.

I AFFIRM UNDER THE PENALTIES FOR PERJURY, that the above and foregoing representations are true and correct.

2009 APR -6 AM 10:50

JOHN LARSON

NORTHWEST INDIANA TITLE
162 WASHINGTON STREET
LOWELL, IN 46356
219-696-0100

STATE OF IND)
)
COUNTY OF Lake)

Subscribed and sworn to before me a Notary Public in and for said County and State this 27 day of March, 2009.

My Commission expires:

NOTARY

County of Resident:

RICHARD A. ZUNICA
Porter County
My Commission Expires
August 31, 2014

$17

THIS INSTRUMENT PREPARED BY: RICHARD A. ZUNICA, Attorney at Law, 162 Washington Street, Lowell, IN 46356

FILE NO. 09-17361

CK

CK# 1697

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.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

APR - 3 2009

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

002413

* **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. 451

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.

July 6, 2006
Date Issued

Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Patricia J. Larson	Female	2:15 AM	June 29, 2006

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day, Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
[redacted]	76			October 8, 1929	Hammond, Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions.)
No	N/A	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
6707 Illinois Ave.	Hammond	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Widowed	N/A	Accounts Receivable Clerk	Electric

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hammond	6707 Illinois Ave.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46323	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White		1

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Hugh Carroll	Mathilda Dahlkamp

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
John Larson	6707 Illinois Ave., Hammond, IN 46323	Son

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	July 6, 2006 Kelly-Carroll Cremation Services	Gary, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Timothy Bowler	FD20500035	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Tara L. Wright	FD20400058	Virgil Huber Funeral Home, 7051 Kennedy Avenue, Hammond, IN 46323 — FH10300032

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. metastatic Lung Carcinoma	year
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	NO	No	No

CERTIFIER

29a. CERTIFIER (Check only one)

☒ 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.	29d. DATE SIGNED (Month, Day, Year)
[signature]	01038049A	7-5-06

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 801 N. Arthur Ave. Suite 201 Munster, In 46321 Mark Kozloff MD

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	July 6, 2006

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☒ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal. *

Local No. 258

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

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

MAR. 23,1999 — Franklin D. Grenuda M.D.
Date Issued — Hammond Health Commission

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED--NAME (First Middle Last): Cecil Wayne Larson "Pete"
2. SEX: Male
3a. TIME OF DEATH: 7:00AM
3b. DATE OF DEATH (Month Day Yr): March 21, 1999
4. SOCIAL SECURITY NUMBER: [redacted]
5a. AGE - Last Birthday (Years): 73
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): March 6, 1926
7. BIRTHPLACE (City and State or Foreign Country): Hammond, IN
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 [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Mercy 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): Patricia Jane Carroll
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Highway Engineer
12b. KIND OF BUSINESS INDUSTRY: Transportation
13a. RESIDENCE - STATE: Indiana
13b. COUNTY: Lake
13c. CITY TOWN OR LOCATION: Hammond
13d. STREET AND NUMBER: 6707 Illinois Avenue
13e. ZIP CODE: 46323
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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); College (1-4 or 5+): 2

PARENTS

18. FATHER'S NAME (First, Middle, Last): John Chester Larson
19. MOTHER'S NAME (First, Middle, Maiden Surname): Hettie Pearl Burgess

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Patricia Jane Larson
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6707 Illinois Avenue, Hammond, IN 46323
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): March 24, 1999 Regional Cremation Services
21c. LOCATION - City or Town State: Munster, Indiana
22a. EMBALMER'S NAME: James W. Gholston
22b. EMBALMER'S LICENSE NO.: FDE1004194
23. WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDE8900006
25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19900009 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

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. LUNG Adenoca — Approximate Interval Between Onset and Death: _____
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

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: [signature]
29c. MEDICAL LICENSE NO: 01048772
29d. DATE SIGNED (Month Day Year): 3/22/99 (Mar 24)

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. R. Chen, 7905 Calumet Ave, Munster, IN 46321
31. HEALTH OFFICER'S SIGNATURE: Franklin D. Grenuda M.D.
32. DATE FILED (Month Day Year): March 23, 1999

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.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3434-08 State No.

1. Decedent's Legal Name (First, Middle, Last)	1a. Maiden Last Name (If Female)	2. Sex	3. Time Of Death	4. Date Of Death (Month/Day/Year)
THOMAS R. LARSON	N/A	M	4:50 PM	DECEMBER 8, 2008

5. Social Security Number	6a. Age Yrs	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
[redacted]	55	Months	Days	Hours	Minutes	June 19, 1953	HAMMOND,INDIANA

9. Ever In U.S. Armed Forces?	10. If Death Occurred In A Hospital:	10a. If Death Occurred Somewhere Other Than A Hospital:
☐ Yes ☒ No Unknown ☐	☐ Inpatient ☐ Emergency Department Outpatient ☐ Dead On Arrival	☐ Hospice Facility ☒ Decedent's Home ☐ Nursing Home/Long-Term Care Facility ☐ Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): 6707 ILLINOIS AVENUE

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
HAMMOND,INDIANA 46323	LAKE	☐ Married ☐ Married, But Separated ☐ Divorced ☐ Widowed ☒ Never Married ☐ Unknown

15. Surviving Spouse's Name	15a. (If Wife)Give Maiden Last Name	16. Decedent's Usual Occupation	17. Kind Of Business/Industry
N/A	N/A	DISABLED	DISABLED

18. Residence – State	18a. County	18b. City Or Town
INDIANA	LAKE	HAMMOND

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
6707 ILLINOIS	N/A	46323	☒ Yes ☐ No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
Associate degree (e.g., AA, AS)	No, not Spanish/Hispanic/Latino	White

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
PETE LARSON	PATRICIA LARSON	CARROLL

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
JOHN LARSON	BROTHER	6707 ILLINOIS AVE. HAMMOND,INDIANA 46323

25. Place Of Disposition

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal From State ☐ Other (Specify):	OAKLAND MEMORY LANES	DOLTON,ILLINOIS

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
☒ Yes ☐ No	KUIPER FUNERAL HOME 9039 KLEINMAN RD. HIGHLAND,INDIANA 46322	FH10300021

27b. Signature Of Indiana Funeral Service Licensee: Leon Smyka

27c. License Number (Of Licensee): FD08800305

Cause Of Death (See Instructions And Examples)

28. Part I. Enter The Chain Of Events—Diseases, Injuries, Or Complications—That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.

Immediate Cause (Final Disease Or Condition Resulting In Death)

Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last

		Approximate Interval: Onset To Death
A.	Congestive Heart failure	
Due To (Or As A Consequence Of):		
B.	Endomyopathy	
Due To (Or As A Consequence Of):		
C.		
Due To (Or As A Consequence Of):		
D.		

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I

29. Was An Autopsy Performed? ☐ Yes ☒ No

30. Were Autopsy Findings Available To Complete The Cause Of Death? ☐ Yes ☒ No

31. Did Tobacco Use Contribute To Death? ☐ Yes ☐ Probably ☒ No ☐ Unknown

32. If Female: ☐ Not Pregnant Within Past Year ☐ Pregnant At Time Of Death ☐ Not Pregnant, But Pregnant Within 42 Days Of Death ☐ Not Pregnant, But Pregnant 43 Days To 1 Year Before Death ☐ Unknown If Pregnant Within The Past Year

33. Manner Of Death: ☒ Natural ☐ Homicide ☐ Accident ☐ Pending Investigation ☐ Suicide ☐ Could Not Be Determined

34. Date Of Injury (Month/Day/Year)	35. Time Of Injury	36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)	37. Injury At Work?
			☐ Yes ☐ No

38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code

39. Describe How Injury Occurred

40. If Transportation Injury, Specify: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify)

41. Signature, Of Person Certifying Cause Of Death:

42. Certifier (Check Only One): ☑ Certifying Physician ☐ Coroner ☐ Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
K. PATEL M.D 525-527 W. Chicago Ave East Chicago, In	01043404	12-10-08

46. Additional Funeral Service Provider:	47. *Akas:

48. Signature of Local Health Officer:	49. For Registrar Only – Date Filed (Month/Day/Year):
Susan J Bust D.O.	December 10, 2008

State Form 10110 (R7/9-07) 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. THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3.7-1-10