

2



TICOR TITLE INSURANCE

2009 035846

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JAMES D. WILKERSON, being first duly

Sworn upon oath, deposes and says:

1. That V. LOUISE WILKERSON
died on 4/19/07 at 12:21 PM

2. That V. LOUISE WILKERSON and JAMES D. WILKERSON
were duly and legally married at the time they acquired title as husband and wife
to the following described real estate:

THE SOUTH 40 FEET OF LOT 15 IN BLOCK 5 IN FORSYTH'S SHEFFIELD
SUBDIVISION, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF,
RECORDED IN PLAT BOOK 15 PAGE 30, IN THE OFFICE OF THE RECORDER
OF LAKE COUNTY, INDIANA.

45-03-06-303-013.000-023

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.

5. That all of the assets of said decedent which would be includable for 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.

[Signature]
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR
JAMES D. WILKERSON

Subscribed and sworn to before me, a Notary Public, this 11TH day of
MAY, 2009

[Signature]
Notary Public: STACI MARIE FINCH

My commission expires: 2/20/16

County of Residence: LAKE



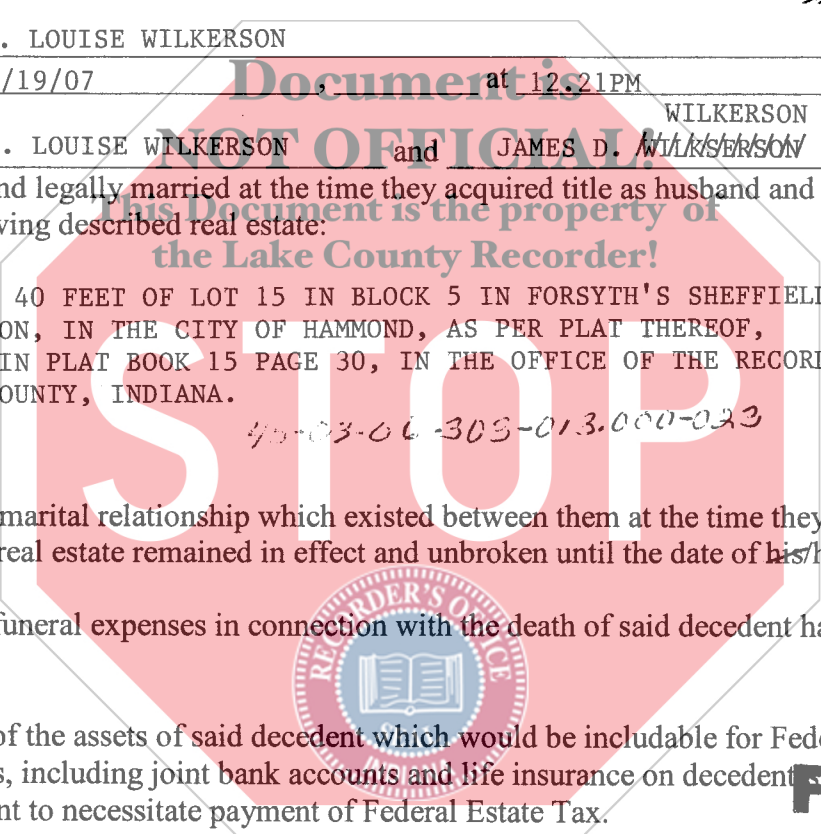
009640

This Instrument prepared by: JAMES D. WILKERSON

"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." Chris Burk

929-2969
TICOR HB7

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MICHAEL A. BROWN
RECORDER
MAY 29 AM 9:19



* 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

State No.

Local No. 92

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) VERNA L. WILKERSON		2 SEX Female		3a TIME OF DEATH 10:21 P.M.		3b DATE OF DEATH (Month, Day, Yr) April 19, 2007	
4 *SOCIAL SECURITY NUMBER [REDACTED]		5a AGE—Last Birthday (Years) 64		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
5 DATE OF BIRTH (Mo, Day, Yr) MARCH 10, 1943		7 BIRTHPLACE (City and State or Foreign Country) HAMMOND IN					
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 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) ST. CATHERINE HOSPITAL			9c CITY, TOWN, OR LOCATION OF DEATH EAST CHICAGO			9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) JAMES WILKERSON		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b KIND OF BUSINESS/INDUSTRY OWN	
13a RESIDENCE—STATE IN		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION HAMMOND / WHITING P.O.		13d STREET AND NUMBER 1333 STANTON	
13e ZIP CODE 46394		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? USA		15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
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+) 2					
18 FATHER'S NAME (First, Middle, Last) JOHN LESTER ABERCROMBE				19 MOTHER'S NAME (First, Middle, Maiden Surname) GLADYS LAMPMAN			
20a INFORMANT'S NAME (Type/Print) JAMES WILKERSON			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1333 STANTON AVE WHITING IN 46394			20c Relationship HUSBAND	
21a METHOD OF DISPOSITION <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) APRIL 23, 2007 RIDGELAWN CEMETERY			21c LOCATION—City or Town, State GARY IN		
22a EMBALMER'S NAME THOMAS OWENS		22b EMBALMER'S LICENSE NO. 1001049		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas Owens</i>		24b LICENSE NUMBER (of Licensee) 1001049		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME OWENS 3007291 816-119TH WHITING IN 46394			
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. Coronary Artery Disease - End stage kidney disease DUE TO (OR AS A CONSEQUENCE OF) 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							Approximate Interval Between Onset and Death
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)			
29a CERTIFIER (Check only one) <input 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. 01058122A		29d DATE SIGNED (Month, Day, Year) 4/23/07		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Carolina Ocampo 3100 45th AVE Suite 3 Highland IN 46322							
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32 DATE FILED (Month, Day, Year) 4/23/07	
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	
34a 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.			