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AFFIDAVIT OF SURVIVORSHIP

ON THIS 9 DAY OF December, 2009, personally appeared Lois M. Carlberg, the affiant, who being duly sworn upon her 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 126 Concord Court, Dyer, Indiana, and described below;
3. Said premises were formerly owned as tenants by the entireties by Frank S. Carlberg and Lois M. Carlberg.
4. Said Frank S. Carlberg died intestate on the 30th day of January, 2007.
5. The legal description of the said premises in question is:

Lot 10, Unit 8, Heritage Estates Addition to the Town of Dyer, as shown in Plat Book 42, Page 33, Lake County, Indiana. Parcel #45-10-01-377-004.000-034

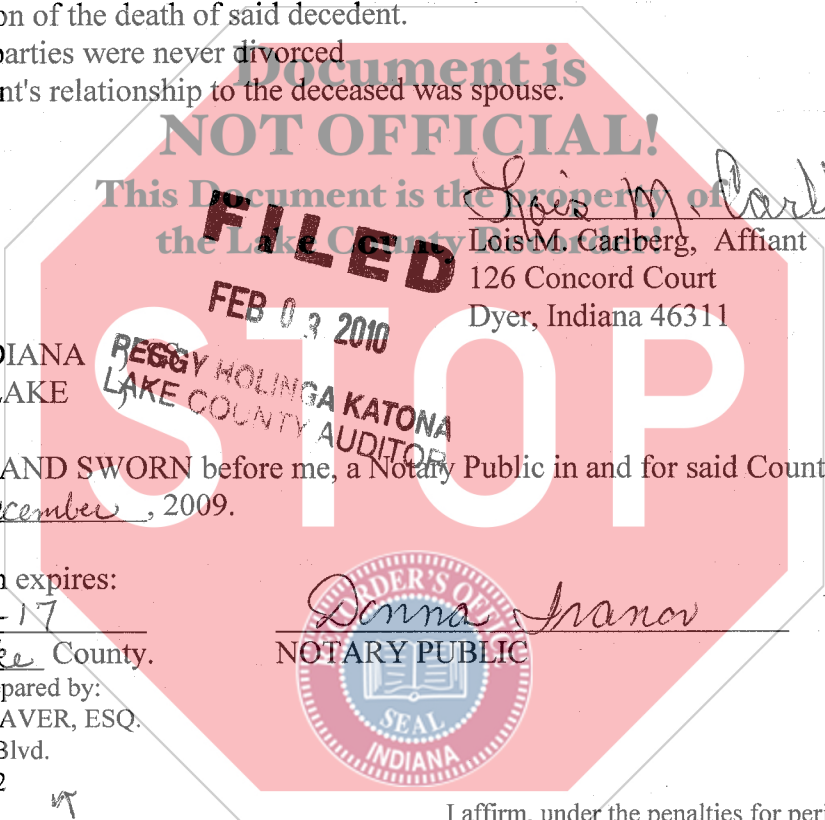
6. To the best of affiant's knowledge, there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent.
7. The parties were never divorced
8. Affiant's relationship to the deceased was spouse.

Lake County Recorder
Michelle R. Fajman

2010 006493

2010 FEB -4 AM 8:19

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD



Lois M. Carlberg
Lois M. Carlberg, Affiant
126 Concord Court
Dyer, Indiana 46311

STATE OF INDIANA
COUNTY OF LAKE

SUBSCRIBED AND SWORN before me, a Notary Public in and for said County and State, this 9 day of December, 2009.

My Commission expires:

10-29-17

Resident of Lake County.

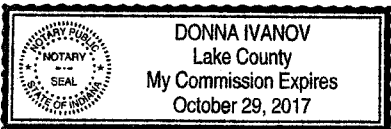
This instrument prepared by:
BARBARA M. SHAVER, ESQ.
9013 Indianapolis Blvd.
Highland, IN 46322
219/838-9200

Donna Ivanov
NOTARY PUBLIC
INDIANA

025305

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



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ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 155-01

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

INFORMANTS

INFORMANT

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1. DECEASED-NAME (First, Middle, Last) Frank STEPHEN Carlberg		2. SEX Male	3a. TIME OF DEATH 9:18 AM	3b. DATE OF DEATH (Month, Day, Year) January 30, 2007
4. SOCIAL SECURITY NUMBER 307-30-5671	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) March 22, 1929
7. BIRTHPLACE (City and State or Foreign Country) DONALDSON, INDIANA	8a. WAS DECEDENT A U.S. VETERAN? YES			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1954		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) XX Residence		
9b. FACILITY NAME (If not institution, give street and number) 126 Concord Court		9c. CITY, TOWN, OR LOCATION OF DEATH Dyer	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Lois WILSON	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) DRIVER		12b. KIND OF BUSINESS/INDUSTRY TRUCKING
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Dyer	13d. STREET AND NUMBER 126 Concord Court	
13e. ZIP CODE 46311	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? <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) RONALD EUGENE CARLBERG		
19. MOTHER'S NAME (First, Middle, Maiden Surname) DAISY CULP		20a. INFORMANT'S NAME (Type/Print) Lois Carlberg		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 126 Concord Court, Dyer, IN 46311		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) FEBRUARY 5, 2007 NORTHWEST INDIANA CREMATION SERVICE		21c. LOCATION - City or Town, State CROWN POINT, INDIANA
22a. EMBALMER'S NAME: MARC MOSQUEDA		22b. EMBALMER'S LICENSE NO. FD08800240	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD20400030	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FAGEN-MILLER FUNERAL HOME FH83001504 1920 HART ST. DYER, IN. 46311	
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. Cardiovascular Collapse		Minutes
DUE TO (OR AS A CONSEQUENCE OF):		b. Arteriosclerotic Heart Disease		Years
DUE TO (OR AS A CONSEQUENCE OF):		c. Arteriosclerosis		Years
DUE TO (OR AS A CONSEQUENCE OF):		d. 		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Pulmonary Hypertension, Hypertension, Diabetes Mellitus				
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
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. 02000901A
29d. DATE SIGNED (Month, Day, Year) 1/31/07		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Michael A. McNamee, D.O. 24 Juliet St Suite 401 Dyer IN 46311		
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) February 1, 2007		
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. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) FEB 6 1 2007		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.		