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2010 012069

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

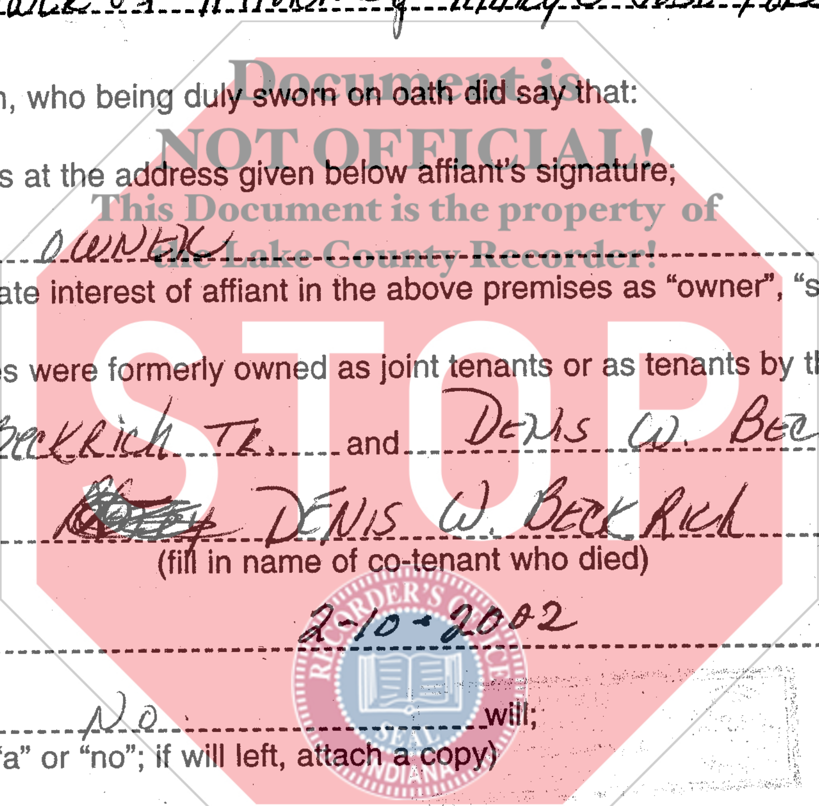
2010 MAR -5 AM 9:17

MICHELLE R. FAJMAN
RECORDER

Chicago Title Insurance Company

620094974

SURVIVORSHIP AFFIDAVIT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On this FEB 26 2010 before me personally appeared Betty J. Beckrich
(insert date)

by her Power of Attorney Mary C. Jose-Fosky

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.)
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Betty J. Beckrich Tr. and Denis W. Beckrich;
4. Said ~~Betty~~ Denis W. Beckrich
(fill in name of co-tenant who died)

died on 2-10-2002

leaving No will;
(insert "a" or "no"; if will left, attach a copy)

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

Lots 6, 7, 8, in Belshaw
PB 11, Page 20 LCI

6. Is there Federal Estate 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.

Chicago Title Insurance Company

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MAR 04 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

15-

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:

NO);

8. Affiant's relationship to the deceased was Spouse

Signature: Betty J Beckrich by her Power of Attorney Mary C. Josefosky

Printed Name Betty J. Beckrich by her Power of Attorney Mary C Jose Fosky

Address: 116 Cheyenne St. Lowell, In.

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Subscribed and sworn to before me by the affiant

this FEB 26 2010

(insert date)

Notary Public

Printed Name

STAR LUGAR
Lake County
My Commission Expires
June 25, 2015

My County of Residence is

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. Star Lugar

In the State of

My Commission Expires

This instrument prepared by Mary C Jose Fosky

* **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. 00 83-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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): Denis W. Beckrich

2 SEX: Male

3a TIME OF DEATH: [illegible] M

3b DATE OF DEATH (Month Day Yr): [illegible] 2002

4. *SOCIAL SECURITY NUMBER: XXXXX 4070

5a AGE—Last Birthday (Years): 66

5b UNDER 1 YEAR — Months / Days

5c UNDER 1 DAY — Hours / Minutes

6 DATE OF BIRTH (Mo. Day. Yr): [illegible]

7 BIRTHPLACE (City and State or Foreign Country): [illegible]

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 ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number): Community Hospital

9c CITY, TOWN OR LOCATION OF DEATH: Munster

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Betty Sullivan

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired): Mill Wright

12b KIND OF BUSINESS/INDUSTRY: Steel Mill

13a RESIDENCE—STATE: IN

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: Lowell

13d STREET AND NUMBER: 20016 Drummond St.

13e ZIP CODE: 46356

13f INSIDE CITY LIMITS: ☒ No ☐ Yes

13g ON A FARM? ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY? USA

15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): John W. Beckrich

19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Agnes Hooper

INFORMANT

20a INFORMANT'S NAME (Type/Print): Betty Beckrich

20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State, Zip Code): 20016 Drummond St, Lowell, IN 46356

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Entombment ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 15, 2002 — Heritage Crematory

21c LOCATION—City or Town, State: Portage, IN

22a EMBALMER'S NAME: William A. Sheets

22b EMBALMER'S LICENSE NO: [illegible]

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Ken Sheets

24b LICENSE NUMBER (of Licensee): FD08900047

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: [illegible] 604 E. Commercial Ave, Lowell, IN [illegible]

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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. Metastatic Lung Cancer — Approximate Interval Between Onset and Death: 2 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): No

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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: [signature]

29c MEDICAL LICENSE NO: 01040756

29d DATE SIGNED (Month, Day, Year): 1-14-02

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Jano — G. JANO, M.D. 7905 CALUMET AVE., MUNSTER, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Susan W. Best D.O.

32 DATE FILED (Month, Day, Year): January 15 2002

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

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1