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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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STATE OF INDIANA

COUNTY OF LAKE

)
) SS: MICHELLE R. FAJMAN
) RECORDER

AFFIDAVIT OF SURVIVORSHIP

I, Sheila M. Callahan, being duly sworn, state as follows:

1. I am over the age of eighteen (18) and suffer from no disability which would render my testimony incompetent.

2. I am the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

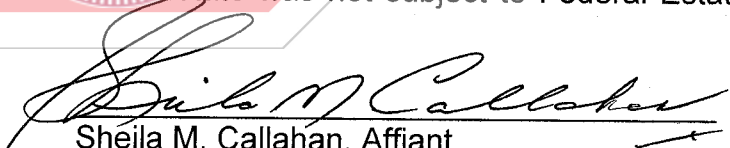
Lot 9, Block 13, Cline Gardens Second Addition to the City of Hammond, Indiana, as per plat thereof, recorded in Plat Book 32, Page 81, in the Office of the Recorder of Lake County, Indiana.

New Tax Key No.: 45-07-10-226-034.000-023
Grantee's Address: 6534 Ohio Avenue, Hammond, IN 46323

3. The decedent, James J. Callahan, and myself acquired title as joint tenants with right of survivorship to said real estate by deed of conveyance on the 23rd day of August, 1973, and recorded in the Office of the Lake County Recorder as Document No. 217686.

4. The decedent and myself jointly held title to said real estate until the death of James J. Callahan on the 12th day of December, 2006, at which time I acquired title to the real estate as the surviving joint tenant pursuant to property law. See attached Death Certificate for James J. Callahan.

5. The gross value of the estate of the decedent as determined for the purpose of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return; therefore, the decedent's estate was not subject to Federal Estate Tax.


Sheila M. Callahan, Affiant

FILED

MAR 12 2010

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

025776

1500
5031
R4

STATE OF INDIANA

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) SS:

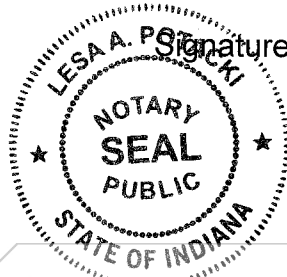
COUNTY OF LAKE

)

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Sheila M. Callahan, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 25th day of February, 2010.

My commission expires: 02/03/2010



Signature:

Lesa A. Potacki

Lesa A. Potacki
Resident of: Lake County, Indiana

"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." /s/Gary P. Bonk

Document is NOT OFFICIAL!

This Document is the property of the Lake County Recorder!

STOP

This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800



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

Local No. 2985-06

State No.

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) JAMES J. CALLAHAN				2. SEX Male		3a. TIME OF DEATH 5:45 AM		3b. DATE OF DEATH (Month, Day, Yr.) December 12, 2006				
4. SOCIAL SECURITY NUMBER 315-16-7807		5a. AGE—Last Birthday (Years) 82		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr.) June 11, 1924		7. BIRTHPLACE (City and State or Foreign Country) Calumet City, Illinois		
8a. WAS DECEDENT A U.S. VETERAN? YES		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		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) THE 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) SHEILA SMITH		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) REFINERY DEPT.				12b. KIND OF BUSINESS/INDUSTRY American Maize Co.				
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION HAMMOND			13d. STREET AND NUMBER 6534 OHIO AVENUE					
13e. ZIP CODE 46323		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		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) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 4		
18. FATHER'S NAME (First, Middle, Last) GEORGE T. CALLAHAN						19. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA RIECHERT						
20a. INFORMANT'S NAME (Type/Print) SHEILA CALLAHAN				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6534 OHIO AVENUE, HAMMOND, IN 46323				20c. Relationship Wife				
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) Dec 15, 2006 ELMWOOD CEMETERY				21c. LOCATION—City or Town, State HAMMOND IN				
22a. EMBALMER'S NAME JOSE G. CORONA				22b. EMBALMER'S LICENSE NO. FDO8601373		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Jose G. Corona</i>				24b. LICENSE NUMBER (of Licensee) FDO8601373		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH10600033 7042 Kennedy Avenue, Hammond, IN 46323						
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) Small Lymphocytic Lymphoma DUE TO (OR AS A CONSEQUENCE OF): Chronic Lymphocytic Leukemia CONDITIONS OF WHICH THIS DEATH IS THE IMMEDIATE RESULT (List only one cause on each line) Stroke, Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Small Lymphocytic Lymphoma DUE TO (OR AS A CONSEQUENCE OF): Chronic Lymphocytic Leukemia 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) No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>M. F. Kevin</i>						29c. MEDICAL LICENSE NO. 01036785		29d. DATE SIGNED (Month, Day, Year) 1/10/06				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) M. F. KEVIN, M.D. 7905 CALUMET AVENUE, MUNSTER, IN 46321-												
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>								32. DATE FILED (Month, Day, Year) January 12, 2007				
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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.								