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2010 013472

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

On this 5th day of MARCH, 2010, before me personally appeared WILLIAM C. JOHNSON, who being duly sworn on his/her oath states the following:

1. That the Affiant is the owner of the real estate located in Lake County, State of Indiana, more particularly described as follows:

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2010 MAR 11 AM 11:41
MICHAEL A. BROWN
RECORDER

LOT 104 IN MEADOWBROOK, PHASES 5, 6, AND 8, IN THE TOWN OF LOWELL AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 86 PAGE 98 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

2. That said premises were formerly owned as tenants by the entireties by WALTER G. JOHNSON AND RUTH B. JOHNSON, husband and wife.

3. That said WALTER G. JOHNSON died on DECEMBER 23, 2009, a resident of Lake County, Indiana, leaving no Will. That said RUTH B. JOHNSON died on September 6, 2006 a resident of Lake County, Indiana, leaving no Will.

4. That by reason of the death of WALTER G. JOHNSON AND RUTH B. JOHNSON, there are no Federal Estate Taxes nor Indiana Inheritance Taxes due and payable by reason of the death of said Decedents.

FURTHER AFFIANT SAITH NOT.

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

William C. Johnson, Trustee
WILLIAM C. JOHNSON
Son of WALTER G. JOHNSON
AND RUTH B. JOHNSON

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, this 5TH day of MARCH, 2010, personally appeared WILLIAM C. JOHNSON and acknowledged the execution of the foregoing affidavit.
IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal.

My Commission Expires:
_____

County of Residence:
_____

Notary Public

SUSAN M. DOWNING
Lake County
My Commission Expires
April 10, 2016

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

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.

FILE NO. 10-18007

FILED
MAR 11 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

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RM

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RECORDER'S OFFICE SEAL INDIANA

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 4369-09 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)
Walter George Johnson		Male	04:12 PM	December 23, 2009

5. Social Security Number	6a. Age – Yrs	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date Of Birth (Month/Day/Year)	8. Birthplace (City And State Or Foreign Country)
311-18-3230	87					January 1, 1922	Hammond, IN

9. Ever In U.S. Armed Forces? [X] Yes [ ] No [ ] Unknown

10. If Death Occurred In A Hospital: [ ] Inpatient [ ] Emergency Department Outpatient [ ] Dead On Arrival

10a. If Death Occurred Somewhere Other Than A Hospital: [X] Hospice Facility [ ] Decedent's Home [ ] Nursing Home/Long-Term Care Facility [ ] Other (Specify)

11. Facility Name (If Not Institution, Give Street And Number): St. Anthony Inpatient Hospice

12. City Or Town, State, And Zip Code	13. County Of Death	14. Marital Status At Time Of Death
Crown Point		[ ] Married [ ] Married, But Separated [ ] Divorced [X] 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		Still Operator	Oil Company

18. Residence – State	18a. County	18b. City Or Town
Indiana	Lake	Lowell

18c. Street And Number	18d. Apt. No.	18e. Zip Code	18f. Inside City Limits?
434 Sycamore Ln.		46356	[X] Yes [ ] No

19. Decedent's Education	20. Decedent Of Hispanic Origin	21. Decedent's Race
High school Graduate or GED	No	Caucasian

22. Father's Name (First, Middle, Last)	23. Mother's Name (First, Middle, Last)	23a. Mother's Maiden Last Name
George Conrad Johnson	Carrie Maude Johnson	Jones

24. Informant's Name	24a. Relationship To Decedent	24b. Mailing Address (Street And Number, City, State, Zip Code)
William Johnson	Son	206 Turin Dr., Schererville, IN 46375

25a. Method Of Disposition	25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)	25c. Location – City, Town, And State
[ ] Burial [X] Cremation [ ] Donation [ ] Entombment [ ] Removal From State [ ] Other (Specify):	Geisen Cremation Centre	Crown Point IN

25. Place Of Disposition

26. Was Coroner Contacted?	27. Name And Complete Address Of Funeral Facility	27a. Funeral Home License Number:
[ ] Yes [X] No	Sheets Funeral Home & Cremation Services 604 E. Commercial Ave., Lowell, IN 46356	FH83004277

27b. Signature Of Indiana Funeral Service Licensee:	27c. License Number (Of Licensee):
Molly Tucker	FD09200061

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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.

		Approximate Interval: Onset To Death
Immediate Cause (Final Disease Or Condition Resulting In Death)	A. Cerebral Vascular Disease	
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	B. Acute Cerebral Vascular Accident (Due To (Or As A Consequence Of))	
	C. Coronary Artery Disease (Due To (Or As A Consequence Of))	
	D. (Due To (Or As A Consequence Of))	

Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I: Diabetis Mellitus II, Hyperlemistor

29. Was An Autopsy Performed? [ ] Yes [X] No

30. Were Autopsy Findings Available To Complete The Cause Of Death? [ ] Yes [X] No

31. Did Tobacco Use Contribute To Death?	32. If Female:	33. Manner Of Death:
[ ] Yes [ ] Probably [ ] No [X] Unknown	[ ] 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	[ ] 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)

I HEREBY CERTIFY THAT THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

41. Signature, Of Person Certifying Cause Of Death: Randall Hile DEC 28 2009

42. Certifier (Check Only One): [X] Certifying Physician [ ] Coroner [ ] Health Officer

43. Name, Address And Zip Code Of Person Certifying Cause Of Death:	44. License Number	45. Date Certified
Dr. Randall Hile MD 1020 E. Commercial Ave., Lowell, IN 46356	01030234	12/28/09

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

48. Signature of Local Health Officer:	49. For Registrar Only – Date Filed (Month/Day/Year):
Susan W Best D.O.	December 28, 2009

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 RECORS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-3 7-1-10

ATTENTION ESTATE: The Social Security # is ing requested by this state agency in order to rsue its statutory responsibility. Disclosure is luntary and there will be no penalty for refusal.

Local No. 2110-06

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

CEDENT

RENTS

FORMANT

SPOSITION

USE OF ATH

RTIFIER

ALTH FICER

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Ruth B. Johnson	Female	09:20 AM	September 6, 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)
312-58-3555	85			August 24, 1921	Merom IN

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
St. Anthony's Medical Center	Crown Point	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
Married	Walter Johnson	Homemaker	Own Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Lowell	434 Sycamore Ln.

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 +)
46356	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Thomas Rehker	Clarissa Cunningham

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Walter G. Johnson	434 Sycamore Ln., Lowell, In 46356	Husband

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)	Sep 8, 2006 Heritage Crematory	Portage IN

22a. EMBALMER'S NAME:	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
N/A	N/A	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD09200061	Sheets Funeral Home FH83004277 604 E. Commercial Ave. Lowell, IN 46356

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. Cardiopulmonary arrest	hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Coronary artery disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: End stage renal disease, Congestive heart failure

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	

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]	10273211	9/7/06

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. Sampanta Boonjarern 297 Franciscan Road, Crown Point, IN 46307

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Susan W Burt D.O.	September 8, 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.

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