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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2010 016171

2010 MAR 22 AM 9:22

SURVIVORSHIP AFFIDAVIT

BT

COMMITMENT/POLICY 1000164

MICHELLE R. FAJMAN
RECORDER

STATE OF INDIANA)
) **SS:**
COUNTY OF LAKE)

CHICAGO TITLE INSURANCE COMPANY

Christine M. Abner, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Michael L. Abner died

(without leaving a will) (leaving a will) on 10-13

20 05 at Porter Valparaiso Hospital Campus

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

LOT 6, BLOCK 4, IN STANDARD ADDITION TO THE CITY OF WHITING, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 6 PAGE 29, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

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 included 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.

Christine M. Abner
Christine M. Abner

Subscribed and sworn to before me, a Notary Public, this 17th day of March, 20 10.

Notary Public

My Commission Expires:

County of Residence:

BRENDA SOHOVICH
Porter County
My Commission Expires
December 28, 2014

This Instrument prepared by Christine M. Abner

#13
CT
CX

025895

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 Brenda Sohovich

(1)

*This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY CERTIFICATE OF DEATH

PORTER COUNTY
HEALTH DEPARTMENT
155 Indiana Ave Suite 104
Valparaiso IN 46383

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)			2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Michael	L.	Abner	Male	2:00 AM	October 13, 2005

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)
[redacted]-4267	58			Jan. 20, 1947	Centertown, Kentucky

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.)
Yes	1970	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
Porter Valparaiso Hospital Campus	Valparaiso	Porter

DECEDENT

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	Christine Miller	Shipping Department	Steel Manufacturing

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Porter	Valparaiso	904 Audubon Drive

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+)
46383	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)		19. MOTHER'S NAME (First, Middle, Maiden Surname)	
Tom	Abner	Lee	Smith

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Christine Abner	904 Audubon Drive, Valparaiso, IN 46383	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	October 17, 2005 St. Mary Cemetery	Kouts, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Jason S. Armstrong	FD29600121	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01019561	Moeller Funeral Home FHS3006821 104 Roosevelt Rd, Valparaiso, IN 46383

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
	b. PULMONARY EMBOLISM	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): c. DEEP VENOUS THROMBOSIS	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.

MORBID OBESITY.

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	- - -

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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
X [signature]	01053495A	10-17-05

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Baghar Mohideen MD 502 Wall Street Suite 101 Valparaiso, IN 46383

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
[signature]	October 17, 2005

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.

SDH06-004 State Form 10110 (R5/1-99)