2

2010 077908

Survivorship Affidavit

State of Indiana)
) SS:
County of Lake)

Bruce Berkman, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Linda Berkman died without leaving a will on

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

All of Lot 25 and the North 25 feet of Lot 26, Block 3, Kelley-Semmes Boulevard Heights Addition to Gary, as shown in Plat Book 9, Page 23, Lake County, Indiana.

2010 DEC 30 PM 1:55
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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 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 includable 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.

Bruce Berkman

Subscribed and sworn to before me, a Notary Public, this day of 12-29, 2010

Danna R. Mista

My Commission expires

DANNA R. MISTA
Lake County
My Commission Expires
July 24, 2018

County of Residence:

This Instrument prepared by: Bruce Berkman

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.
PREPARED BY: BB

920074532

FILED
DEC 30 2010
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

AMOUNT $ 14
CASH ✓ CHARGE
CHECK #
OVERAGE
COPY
NON-COM ✓
CLERK KG

031221

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.

ocal No. 799-05

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): **Linda Joy Berkman**
2. SEX: Female
3a. TIME OF DEATH: M
3b. DATE OF DEATH (Month, Day, Yr.): March 11, 2005
4. *SOCIAL SECURITY NUMBER: 311-58-2322
5a. AGE—Last Birthday (Years): 53
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo. Day, Yr.): February 12, 1952
7. BIRTHPLACE (City and State or Foreign Country): Gary, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
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): 9472 Madison Place Apt. 1114
9c. CITY, TOWN, OR LOCATION OF DEATH: Crown Point
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Divorced
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): Agent
12b. KIND OF BUSINESS/INDUSTRY: Insurance
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Crown Point
13d. STREET AND NUMBER: 9472 Madison Place Apt. 1114
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): Samuel Cohen
19. MOTHER'S NAME (First, Middle, Maiden Surname): Maisie Volke

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sam Berkman
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 S. Butler Blvd. Lansing, MI 48915
20c. Relationship: Son

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): March 16, 2005 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana 46410
22a. EMBALMER'S NAME: Jeffery N. Sachs
22b. EMBALMER'S LICENSE NO.: FD29800086
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Jeffrey N. Sachs
24b. LICENSE NUMBER (of Licensee): FD29800086
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Ridgelawn Funeral Home FH10200007, 4201 West Ridge Road Gary, IN 46408

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. OVARIAN CARCINOMA	1 Year
	DUE TO (OR AS A CONSEQUENCE OF)	
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.	

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): 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: B Barai
29c. MEDICAL LICENSE NO.: 01030107
29d. DATE SIGNED (Month, Day, Year): 3-18-05
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. B Barai 200 E. 89th Ave Suite 2-A Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan M Burt D.O.
32. DATE FILED (Month, Day, Year): March 21, 2005

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.:

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