

7

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.

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.

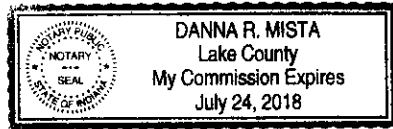
Further affiant sayeth not.

Bruce Berkman

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

Danna R. Mista

My Commission expires



County of Residence:

This Instrument prepared by: Bruce Berkman

AMOUNT \$ 14
CASH CHARGE _____
CHECK # _____
OVERAGE _____
COPY _____
NON-COM
CLERK RJ

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: B.B.

920074532

FILED

DEC 30 2010

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

031221

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2010 DEC 30 PM 1:58
RECORDER

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 799-05

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

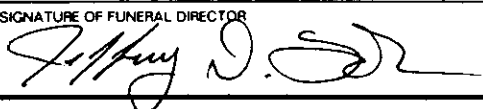
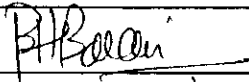

FORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH OFFICER

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: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> 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 <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): 12 College (1-4 or 5+)			
18 FATHER'S NAME (First, Middle, Last) Samuel Cohen						19 MOTHER'S NAME (First, Middle, Maiden Surname) Maisie Volke							
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					
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) 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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a SIGNATURE OF FUNERAL DIRECTOR 				24b LICENSE NUMBER (of Licensee) FD29800086		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Ridgelawn Funeral Home 4201 West Ridge Road Gary, IN 46408 FH10200007							
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			
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last													
b. _____													
c. _____													
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			
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 								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													
31. HEALTH OFFICER'S SIGNATURE 										32. DATE FILED (Month, Day, Yr.) March 18, 2005			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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			
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.							