

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2011 029518

2011 MAY 27 PM 12:34

MICHAEL J. ...
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

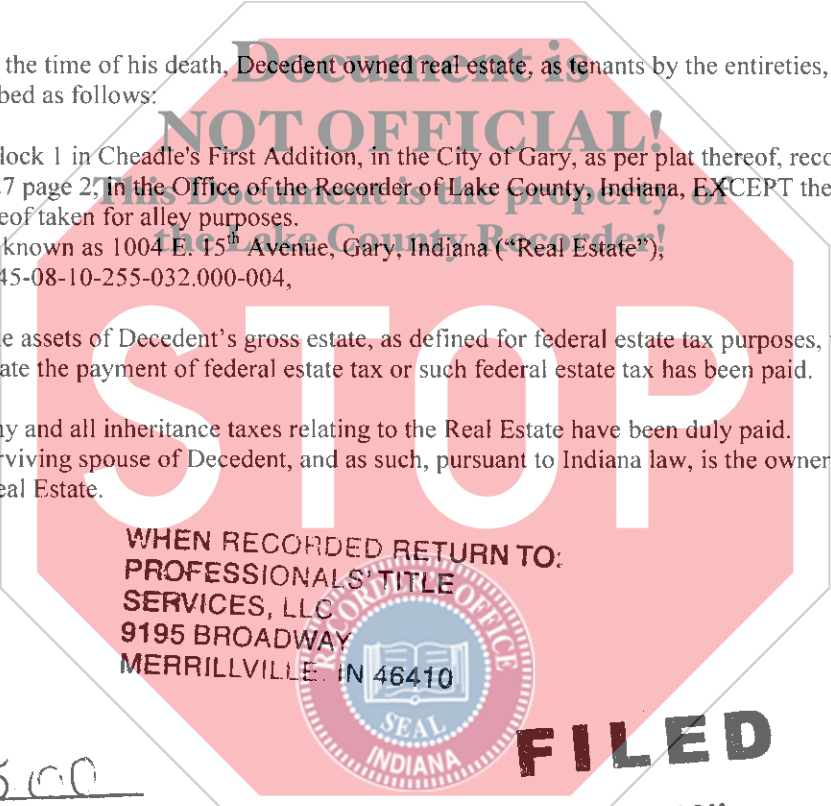
SURVIVORSHIP AFFIDAVIT

Pinkey Greer, of Lake County, Indiana, being first duly sworn upon oath, states as follows:

1. Affiant is the surviving spouse of J.D. Greer ("Decedent"), and is qualified to make this Affidavit.
2. Decedent died a resident of Lake County, Indiana, on September 16, 2005. A copy of Decedent's death certificate is attached as Exhibit "A."
3. At the time of his death, Decedent was married to Pinkey Greer, and they were not legally separated.
4. At the time of his death, Decedent owned real estate, as tenants by the entireties, with Pinkey Greer, legally described as follows:

Lot 67 in Block 1 in Cheadle's First Addition, in the City of Gary, as per plat thereof, recorded in Plat Book 27 page 2, in the Office of the Recorder of Lake County, Indiana, EXCEPT the North 10 feet thereof taken for alley purposes.
 Commonly known as 1004 E. 15th Avenue, Gary, Indiana ("Real Estate");
 Parcel No. 45-08-10-255-032.000-004,
5. The assets of Decedent's gross estate, as defined for federal estate tax purposes, were either not sufficient to necessitate the payment of federal estate tax or such federal estate tax has been paid.
6. Any and all inheritance taxes relating to the Real Estate have been duly paid.
 Pinkey Greer is a surviving spouse of Decedent, and as such, pursuant to Indiana law, is the owner of all right, title, and interest to the Real Estate.

PTS11-6119



AMOUNT \$ 15.00
 CASH _____ CHARGE _____
 CHECK # 3392
 OVERAGE _____
 COPY _____
 NON-COM _____
 CLERK LK

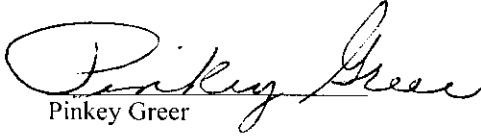
FILED

MAY 27 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

001927

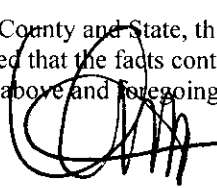
Dated this 25th day of May, 2011.


Pinkey Greer

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

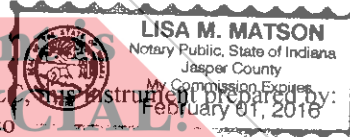
Before me, the undersigned, a Notary Public in and for said County and State, this 25th day of May, 2011, personally appeared Pinkey Greer, who, being duly sworn, stated that the facts contained in the foregoing Affidavit are true and correct and acknowledged the execution of the above and foregoing Affidavit.

WITNESS my hand and Notarial Seal.

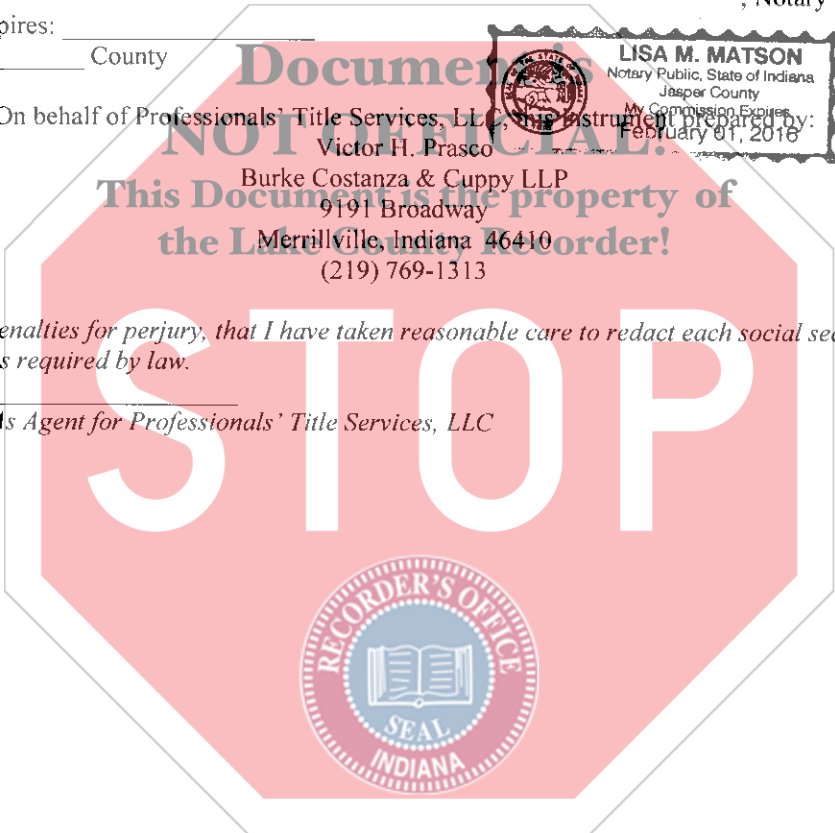


_____, Notary Public


My Commission Expires: _____
Resident of _____ County



On behalf of Professionals' Title Services, LLC, this instrument prepared by:
Victor H. Prasco
Burke Costanza & Cuppy LLP
9191 Broadway
Merrillville, Indiana 46410
(219) 769-1313



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.

By: 
Lisa M. Matson As Agent for Professionals' Title Services, LLC

ATTENTION: The Social Security # is 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

State No.

05 0528

Local 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) **J. D. GREER**

2. SEX **MALE**

3a. TIME OF DEATH **8:07p.m.**

3b. DATE OF DEATH (Month, Day, Year) **SEPTEMBER 16, 2005**

4. SOCIAL SECURITY NUMBER **XX-XX-2183**

5a. AGE—Last Birthday (Years) **72**

5b. UNDER 1 YEAR (Months, Days)

5c. UNDER 1 DAY (Hours, Minutes)

6. DATE OF BIRTH (Mo, Day, Yr) **JULY 23, 1933**

7. BIRTHPLACE (City and State or Foreign Country) **VAUGHN, MISSISSIPPI**

8a. WAS DECEDENT A U.S. VETERAN? **NO**

8b. YEAR LAST SERVED IN U.S. ARMED FORCES?

9. PLACE OF DEATH (Check only one. See instructions.)
 HOSPITAL Inpatient ER/Outpatient DOA
 OTHER Nursing Home Other (Specify) Residence

9a. FACILITY NAME (If not institution, give street and number) **METHODIST HOSPITAL (NORTHLAKE)**

9b. CITY, TOWN, OR LOCATION OF DEATH **GARY**

9c. COUNTY OF DEATH **LAKE**

10. MARITAL STATUS (Specify) **MARRIED**

11. SURVIVING SPOUSE (If wife, give maiden name) **PENKEY JOSEPH**

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **EYE RAILROAD**

12b. KIND OF BUSINESS/INDUSTRY **RAILROAD**

13a. RESIDENCE—STATE **INDIANA**

13b. COUNTY **LAKE**

13c. CITY, TOWN, OR LOCATION **GARY**

13d. STREET AND NUMBER **1004 E. 15th AVE**

13e. ZIP CODE **46407**

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) **BLACK**

17. DECEDENT'S EDUCATION (Specify only highest grade completed)
 Elementary/Secondary (0-12) College (1-4 or 5+)

18. FATHER'S NAME (First, Middle, Maiden Surname) **WILLIAM GREER**

19. MOTHER'S NAME (First, Middle, Maiden Surname) **MABEL TAYLOR**

20a. INFORMANT'S NAME (Type/Print) **PENKEY GREER**

20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1004 E. 15th AVE GARY, IN 46407**

20c. Relationship **WIFE**

21a. METHOD OF DISPOSITION Burial Cremation Removal from State Donation Other (Specify)

21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **SEPT. 23, 2005 EVERGREEN CEMETERY**

21c. LOCATION—City or Town, State **HOBART, INDIANA**

22a. EMBALMER'S NAME **D. LEE CAMMACK**

22b. EMBALMER'S LICENSE NO. **20000021**

23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *[Signature]*

24b. LICENSE NUMBER (of Licensee) **20000021**

25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **SERENITY GARDENS CH - 14300007 934 E. 21st AVE GARY, IN 46407**

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)
X ACUTE MASSIVE PULMONARY EMBOLISM.
 DUE TO IOR AS A CONSEQUENCE OF

Conditions, if any, which give rise to the immediate cause, stating the underlying cause last

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) **YES**

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)
 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 *[Signature]*

29c. MEDICAL LICENSE NO. **X 01041856**

29d. DATE SIGNED (Month, Day, Year) **9-26-05**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
X PAUL C. OKOLOCHA M.D., 2054 GARY IN 46404

31. HEALTH OFFICER'S SIGNATURE *[Signature]*

32. DATE FILED (Month, Day, Year) **SEP 27 2005**

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

Received Time—May 20, - 4:02PM
SDH06-004 State Form 10110 (R5/1-99)