

2.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA)
COUNTY OF LAKE)

2011 SS: 044035

2011 AUG 16 PM 2:06

AFFIDAVIT OF SURVIVORSHIP

Comes now Albert P. Tharp, and upon being duly sworn does attest and say:

1. That the affiant is the son of Ralph E. Tharp, deceased, and Mary H. Tharp.
2. That Ralph E. Tharp and Mary H. Tharp, husband and wife, were the owners of real property located in Lake County, Indiana, more particularly described as:

Lot 28, Block 11, Country Club Estates Subdivision, as recorded in the Office of the Recorder, Lake County, IN

Commonly known as: 104 N. Cavender St., Hobart, IN 46342
Parcel NO.: 45-09-30-352-032.000-018
3. That Ralph E. Tharp and Mary H. Tharp acquired the property during the term of their marriage.
4. That Ralph E. Tharp died on the 17th day of May, 2009.
5. That Mary H. Tharp became the fee simple owner of the property at the death of Ralph E. Tharp.

I affirm under the penalties for perjury that the foregoing statements are true.



Albert P. Tharp
Albert P. Tharp

STATE OF INDIANA)
COUNTY OF PORTER)SS:
Subscribed and sworn to before me this 29 day of July, 2011.

My Commission
Expires: 10/30/2016

Susan R. Colunga
Susan R. Colunga, Notary Public
Resident of Porter County

I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

Patricia A. Rees
Patricia A. Rees

This Instrument Prepared by: Patricia A. Rees, Attorney at Law, 5341 Central Ave., Portage, IN 46368
(219) 947-1692.

AMOUNT \$ 14
 CASH _____ CHARGE _____
 CHECK # 11097
 OVERAGE _____
 COPY _____
 NON-COM _____
 CLERK Ray

054845

FILED

AUG 16 2011

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

**STATE OF ILLINOIS
CERTIFICATE OF DEATH**

REGISTRATION DISTRICT NO. 18.10		STATE FILE NUMBER	
LOCAL FILE NUMBER		STATE FILE NUMBER	
1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) RALPH THARP		2. SEX MALE	3. DATE OF DEATH (Month/Day/Year) (Spell Month) MAY 17, 2009
4. COUNTY OF DEATH COOK	5a. AGE AT LAST BIRTHDAY (Years) 62	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____
7a. CITY OR TOWN CHICAGO		7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number) MARLY HOSPITAL & MEDICAL CENTER	
7c. PLACE OF DEATH (Check only one: see instructions)			
IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival		IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing Home/Long-term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify): _____	
8. BIRTHPLACE (City and State or Foreign Country) Cambridge, MA	9. SOCIAL SECURITY NUMBER 305-46-0497	10. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown	11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage) MARY WITT
12. EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13a. RESIDENCE (Street and Number) 104 W. CONNELLER ST.	13b. APT. NO. -	13c. CITY OR TOWN HOBART, INDIANA
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13e. COUNTY LAKE	13f. STATE IND.	13g. ZIP CODE 46842
14. FATHER'S NAME (First, Middle, Last) RICHARD THARP	15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) MARY CATHERINE THARP		
16a. INFORMANT'S NAME MARY THARP	16b. RELATIONSHIP WIFE	16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code) 104 W. CONNELLER ST. HOBART, IN.	
17. METHOD OF DISPOSITION: <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify): _____	18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) CALVARY CEMETERY	19. LOCATION - CITY, TOWN AND STATE PARMOUTH, INDIANA	20. DATE OF DISPOSITION (Month/Day/Year) 5-20-09
21a. FUNERAL HOME NAME GRIMM FUNERAL HOME	NAME BOULEVARD ST	STREET AND NUMBER ISLETALE, ILLINOIS	CITY OR TOWN 60439
21b. FUNERAL DIRECTOR'S SIGNATURE <i>Anthony Corporat</i>	21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER 034-012412		
22. LOCAL REGISTRAR'S SIGNATURE <i>May Thomas</i>	23. DATE FILED WITH LOCAL REGISTRAR (Month/Day/Year) 051909		
24. CAUSE OF DEATH (See instructions and examples) 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 etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROBABLE MYOCARDIAL INFARCTION Due to (or as a consequence of): _____ 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. HYPERTENSION Due to (or as a consequence of): _____ c. _____ 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.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
25. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown	26. IF FEMALE: <input type="checkbox"/> Not pregnant within past 12 months <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death	27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation	
28. DATE OF INJURY (Month/Day/Year)	29. TIME OF INJURY <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	30. PLACE OF INJURY (e.g. Decedent's home; construction site; restaurant; wooded area)	31. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
32. LOCATION OF INJURY Street and Number	Apartment Number	City or Town	State ZIP Code
33. DESCRIBE HOW INJURY OCCURRED:		34. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify): _____	
35. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON 4-08-09	36. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	37. DATE PRONOUNCED (Month/Day/Year) MAY 17, 2009	38. TIME OF DEATH 2:52 <input type="checkbox"/> A.M. <input checked="" type="checkbox"/> P.M.
41. CERTIFIER (Check only one): <input type="checkbox"/> Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner/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 stated.			
42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) MARIE APPLEBAUM H.D. 345 E. Superior St. CHICAGO, ILL.		43. PHYSICIAN'S LICENSE NUMBER 36-091348	
44. TITLE OF CERTIFIER DOCTOR	45. DATE CERTIFIED (Month/Day/Year) 5-18-09	46. SIGNATURE OF CERTIFIER <i>Dr. Applebaum</i>	

This is to certify that this is a true and correct copy of the official death record filed with the Illinois Department of Public Health.

CITY OF CHICAGO
DEPARTMENT OF PUBLIC HEALTH

THIS CERTIFICATE COPY VALID WHEN
EMBOSSER SEAL IS APPLIED OVER
REGISTRAR'S SIGNATURE

Cherry Mason MD

I, TERRY MASON, M.D., LOCAL REGISTRAR OF VITAL STATISTICS OF THE CITY OF CHICAGO, HEREBY CERTIFY THAT I AM THE KEEPER OF THE RECORDS OF BIRTH, STILLBIRTH AND DEATH FOR THE CITY OF CHICAGO BY VIRTUE OF THE LAWS OF THE STATE OF ILLINOIS AND THE ORDINANCES OF THE CITY OF CHICAGO. THAT THE ACCOMPANYING CERTIFICATE ON THIS SHEET IS A TRUE COPY OF A RECORD KEPT BY ME IN OBEYANCE OF SAID LAWS AND ORDINANCES.

STATE OF ILLINOIS
COUNTY OF COOK
CITY OF CHICAGO
MAY 19 2009