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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2011 044571

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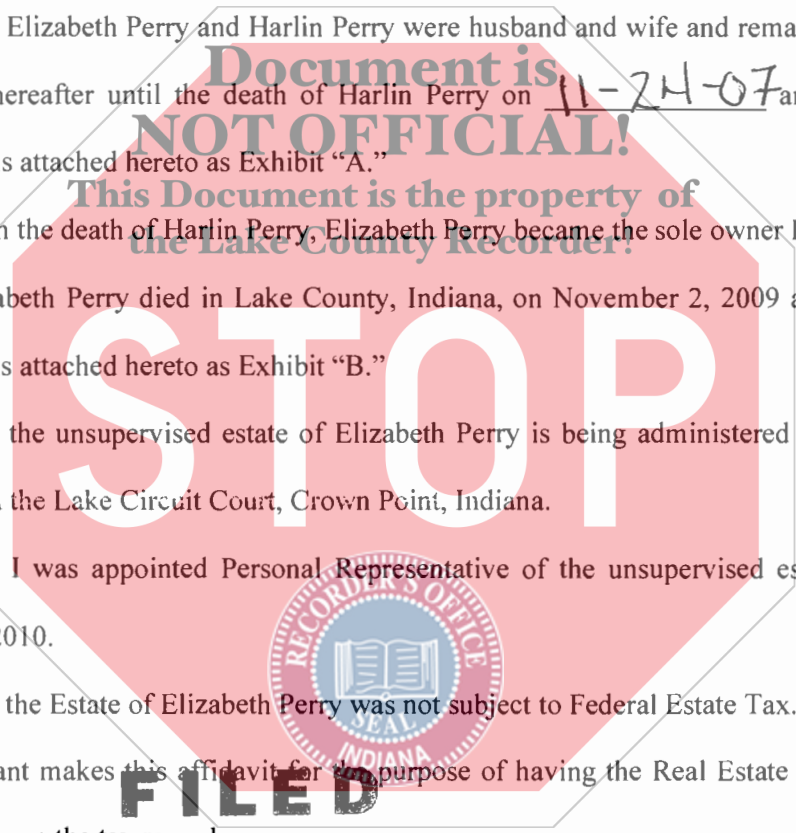
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SURVIVORSHIP AFFIDAVIT

Lisa J. Rosinko, being first duly sworn upon oath deposes and says:

1. That I am one of the five (5) surviving adult grandchildren and heirs of Elizabeth Perry.
2. Elizabeth Perry and Harlin Perry were the joint owners of four (4) vacant lots located in Schneider, Lake County, Indiana identified as .57 acres of Lot 384, .86 acres of Lot 420, .28 acres of Lot 421, and .30 acres of Lot 422 to the City of Schneider ("Real Estate").
3. That Elizabeth Perry and Harlin Perry were husband and wife and remained husband and wife continuously thereafter until the death of Harlin Perry on 11-24-07 and a copy of the Certificate of Death is attached hereto as Exhibit "A."
4. Upon the death of Harlin Perry, Elizabeth Perry became the sole owner Real Estate.
5. Elizabeth Perry died in Lake County, Indiana, on November 2, 2009 and a copy of the Certificate of Death is attached hereto as Exhibit "B."
4. That the unsupervised estate of Elizabeth Perry is being administered under Cause No. 45C01-1001-EU-1 in the Lake Circuit Court, Crown Point, Indiana.
5. That I was appointed Personal Representative of the unsupervised estate of Elizabeth Perry on January 6, 2010.
6. That the Estate of Elizabeth Perry was not subject to Federal Estate Tax.
7. Affiant makes this affidavit for the purpose of having the Real Estate transferred to the name of Jessie Brown on the tax records.



054884

AUG 17 2011
PEGGY HOLINGA KATON
LAKE COUNTY AUDITOR

AMOUNT \$ 17⁰⁰
 CASH _____ CHARGE _____
 CHECK # 4416
 OVERAGE _____
 COPY _____
 NON-COM _____
 CLERK 1383

E

I affirm under the penalties for perjury the above is true to the best of my knowledge and belief.

Dated this 23rd day of June, 2011.

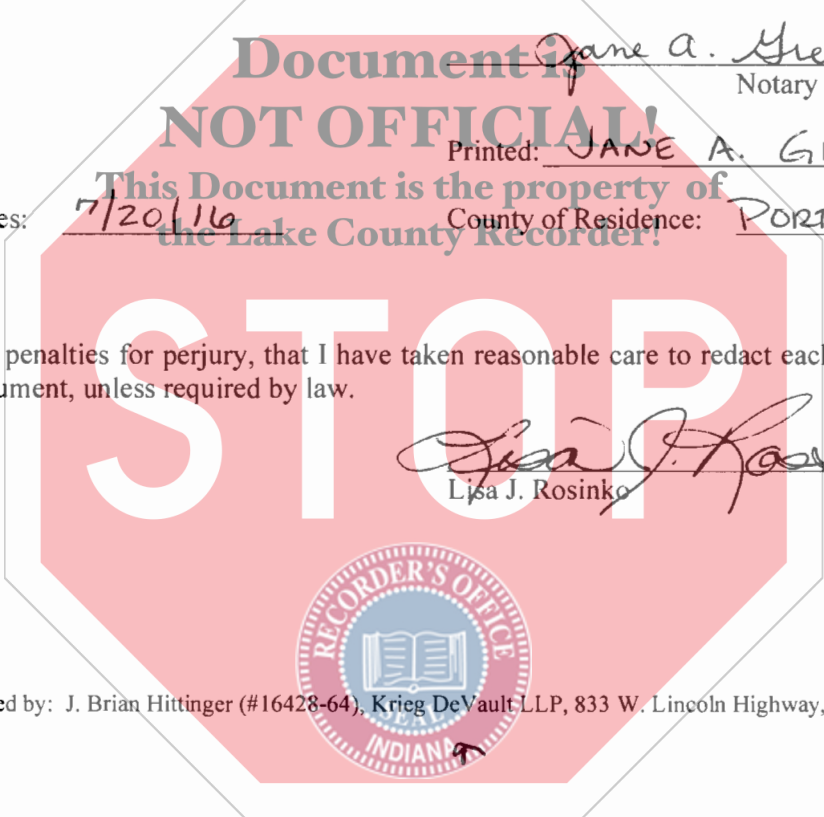
Lisa J. Rosinko
Lisa J. Rosinko

Before me, the undersigned, a Notary Public in and for said County and State, this 23 day of June, 2011, personally appeared Lisa J. Rosinko in her capacity as Personal Representative of Estate of Elizabeth Perry, Deceased, and acknowledged the execution of the foregoing Survivorship Affidavit.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal.

Jane A. Grennes
Notary Public
Printed: JANE A. GRENNES
County of Residence: PORTER

Commission Expires: 7/20/16



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.

Lisa J. Rosinko
Lisa J. Rosinko

This instrument prepared by: J. Brian Hittinger (#16428-64), Krieg DeVault LLP, 833 W. Lincoln Highway, Suite 410W, Schererville, IN 46375

KD_3487223_1.DOC

* ATTENTION ESTATE: The Social Security # is being 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

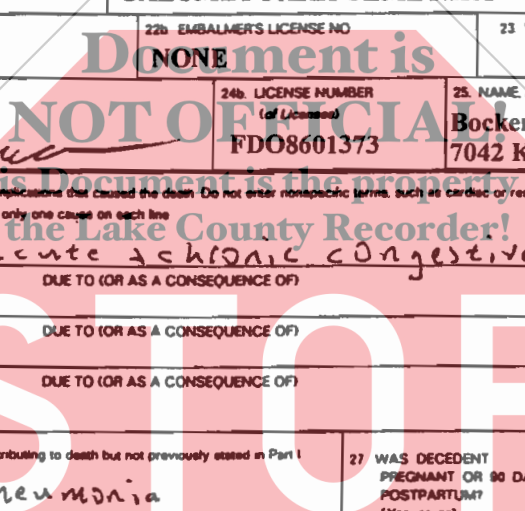
State No.

Local No. 274

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

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) HARLIN E. PERRY				2. SEX Male		3a. TIME OF DEATH 11:50 PM_M		3b. DATE OF DEATH (Month, Day, Yr) November 24, 2007	
4. SOCIAL SECURITY NUMBER 338-18-2482		5a. AGE—Last Birthday (Years) 85		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) June 9, 1922	
7. BIRTH-PLACE (City and State or Foreign Country) GOREVILLE, ILLINOIS		8a. WAS DECEDENT A U.S. VETERAN? YES							
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence							
9a. FACILITY NAME (If not institution, give street and number) Lake County Nursing & Rehab						9b. CITY, TOWN, OR LOCATION OF DEATH East Chicago		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) ELIZABETH (not available)		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) WELDER		12b. KIND OF BUSINESS/INDUSTRY Steel Worker			
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION HAMMOND		13d. STREET AND NUMBER 3805-177th STREET			
13e. ZIP CODE 46323		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) IRA PERRY				19. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN MARTIN			
20a. INFORMANT'S NAME (Type/Private) Catherine D. Huling				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 668 Bristol Street, Pingree Grove, IL 60140				20c. Relationship GREAT NIECE	
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) Dec 1, 2007 CALUMET PARK CEMETERY				21c. LOCATION—City or Town, State MERRILLVILLE IN	
22a. EMBALMERS NAME NONE				22b. EMBALMER'S LICENSE NO. NONE		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b. LICENSE NUMBER (of Licensee) FDO8601373		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Bocken Funeral Home, Inc. FH10600033 7042 Kennedy Avenue, Hammond, IN 46323			
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. acute atherosclerotic congestive heart failure 1-2 days DUE TO (OR AS A CONSEQUENCE OF)									
b. _____ DUE TO (OR AS A CONSEQUENCE OF)									
c. _____ DUE TO (OR AS A CONSEQUENCE OF)									
d. _____ DUE TO (OR AS A CONSEQUENCE OF)									
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I acute bronchopneumonia									
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No				28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes			
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 <i>[Signature]</i>						29c. MEDICAL LICENSE NO. 01048374A		29d. DATE SIGNED (Month, Day, Year) 11-28-07	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Private) JAMES BRYANT, M.D. 333 N. MICHIGAN, CHICAGO, IL 60601									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>							32. DATE FILED (Month, Day, Year) 11/28/07		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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		
34a. 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.					





INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No. 3751-09

State No.

Form containing fields for decedent information (ELIZABETH PERRY SCHLARP), date of death (November 2, 2009), cause of death (End Stage Dementia), certifier information (A. SHEIKH, M.D.), and registrar information (November 4, 2009).

