2

Survivorship Affidavit

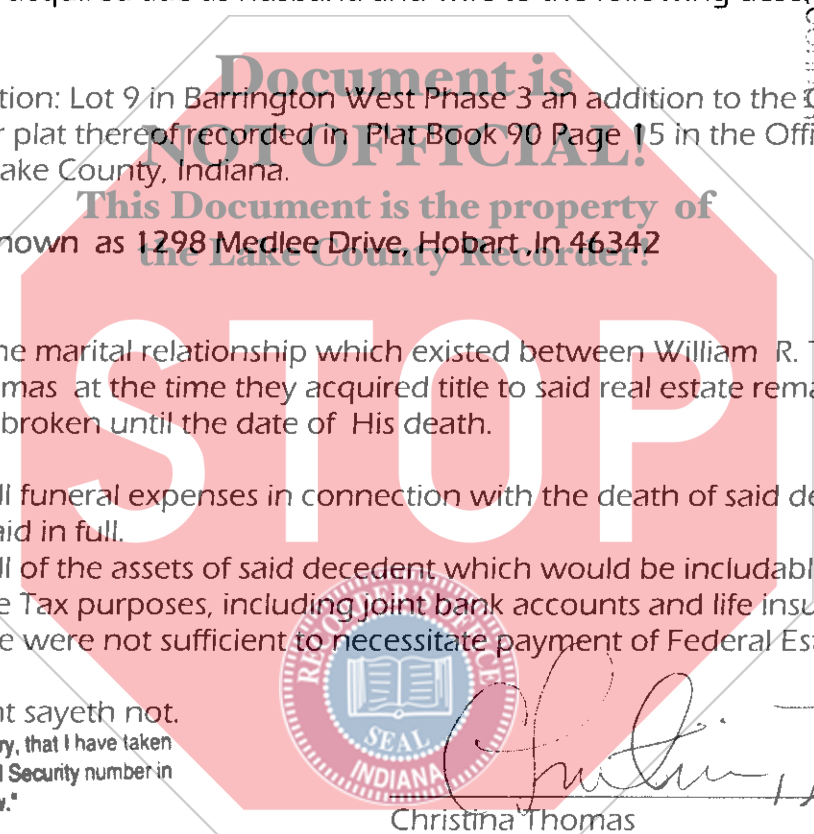
2011 051016

State of Indiana)
) SS:
County of Lake)

Christina Thomas being first duly sworn upon oath, deposes and says:

1. That Affiant's Husband died without leaving a will (copy of death certificate attached) on May 5, 2005.

2. William R. Thomas and Christina Thomas were duly and legally married at the time they acquired title as husband and wife to the following described real estate: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Legal description: Lot 9 in Barrington West Phase 3 an addition to the City of Hobart as per plat thereof recorded in Plat Book 90 Page 15 in the Office of the Recorder of Lake County, Indiana.

Commonly Known as 1298 Medlee Drive, Hobart ,In 46342

3. That the marital relationship which existed between William R. Thomas and Christina Thomas at the time they acquired title to said real estate remained in effect and unbroken until the date of His death.

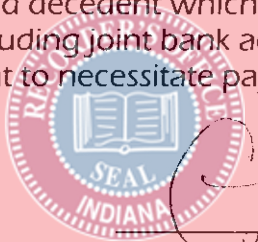
4. That all funeral expenses in connection with the death of said decedent have been paid in full.

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.

"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."

Daianna Tarlton



Christina Thomas

Subscribed and sworn to before me, a Notary Public, this 26th day of August 2011

Paula Barrick

My Commission expires: 10-02-17

County of Residence:Lake

PAULA BARRICK
Lake County
My Commission Expires
Oct. 2, 2017

This Instrument prepared by: ~~Olga Cunningham~~ Christina Thomas

File No. : 920112795

merr.

FIDELITY MO

055720

FILED
SEP 13 2011
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

13
AO
FW

Sep. 2. 2011 10:44AM No. 7629 P.

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.

Local No. 1306-05

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. Decedent—Name (First, Middle, Last): WILLIAM R. THOMAS
2. Sex: Male
3a. Time of Death: 6:10 PM
3b. Date of Death (Month, Day, Yr): May 5, 2005
4. Social Security Number: [redacted]
5a. Age—Last Birthday (Years): 74
5b. Under 1 Year (Months, Days):
5c. Under 1 Day (Hours, Minutes):
6. Date of Birth (Mo, Day, Yr): November 13, 1930
7. Birthplace (City and State or Foreign Country): Gary Indiana
8a. Was Decedent a U.S. Veteran? YES
8b. Year Last Served in U.S. Armed Forces? 1953
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): 1298 Medlee Dr.
9c. City, Town, or Location of Death: Hobart
9d. County of Death: Lake
10. Marital Status (Specify): Married
11. Surviving Spouse (If wife, give maiden name): Christina Campbell
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired): Supervisor
12b. Kind of Business/Industry: Steel
13a. Residence—State: Indiana
13b. County: Lake
13c. City, Town, or Location: Hobart
13d. Street and Number: 1298 Medlee Dr.
13e. Zip Code: 46342
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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☒ No ☐ Yes — American
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): John Thomas
19. Mother's Name (First, Middle, Maiden Surname): Anna Cirak

INFORMANT

20a. Informant's Name (Type/Print): Christina Thomas
20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1298 Medlee Dr., Hobart, In 46342
20c. Relationship: Wife

DISPOSITION

21a. Method of Disposition: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. Date and Place of Disposition (Name of cemetery, crematory, or other place): May 9, 2005 Calvary Crematory
21c. Location—City or Town, State: Portage IN
22a. Embalmer's Name: James J. Krause
22b. Embalmer's License No.: FD01006463
23. Was Death Reported to Coroner? ☒ No ☐ Yes
24a. Signature of Funeral Director: James J. Krause
24b. License Number (of Licensee): FD01006463
25. Name, Address and License Number of Funeral Home: Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

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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.

Immediate cause (Final disease or condition resulting in death) / Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		Approximate Interval Between Onset and Death
a.	ACUTE LEUKEMIA	6 Months
b. Due to (or as a consequence of)	Myelodysplastic Syndrome	1 Year
c. Due to (or as a consequence of)	LYMPHOMA	10 Yrs
d. Due to (or as a consequence of)		

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: [signature]
29c. Medical License No.: 01030107
29d. Date Signed (Month, Day, Year): 5-10-05
30. Name and Address of Person Who Completed Cause of Death (Item 26) (Type/Print): Bharat H. Barai MD 200 E. 89th Ave, Suite 2A, Merrillville, IN 46410

HEALTH OFFICER

31. Health Officer's Signature: [signature] D.O.
32. Date Filed (Month, Day, Year): May 10, 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.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT
MAY 1 0 2005

SDH06-004 State Form 10110 (R6/1-99)