

3

HEIRSHIP AFFIDAVIT

That Tara M. Roman, being first duly sworn upon her oath, deposes and states as follows:

1. That Tara M. Roman and Tiffany M. Latham are the children and sole heirs of Jacqueline M. Roman (hereinafter referred to as "Decedent") who the record title owner of the following described real estate located in Lake County, Indiana:

Lot 5 in Block 1 in Quail Meadows, Unit No. 1, in the City of Crown Point, as per plat thereof, recorded in Plat Book 54 Page 18, and amended by Certificate of Correction recorded July 1, 1988 as Document No. 714715, in the Office of the Recorder of Lake County, Indiana.

More commonly known as: 840 Wirtz Court, Crown Point, Indiana 46307 (Parcel No. 45-16-06-430-005-000-042)

2. That the Decedent departed this life on the 8th day of May, 2011 while domiciled in Lake County, Indiana.

3. That pursuant to I.C. §29-1-7-23 and I.C. §29-1-2-1(d)(1), the above-described real estate vested in Tara M. Roman and Tiffany M. Latham upon the death of the Decedent without the necessity of probate administration.

4. That there was no inheritance or estate tax due as a result of the death of the Decedent.

5. That the purpose of this Heirship Affidavit is to show the death of the Decedent and to transfer ownership in the above-described real estate from the Decedent to Tara M. Roman and Tiffany M. Latham.

Further, Affiant sayeth naught.

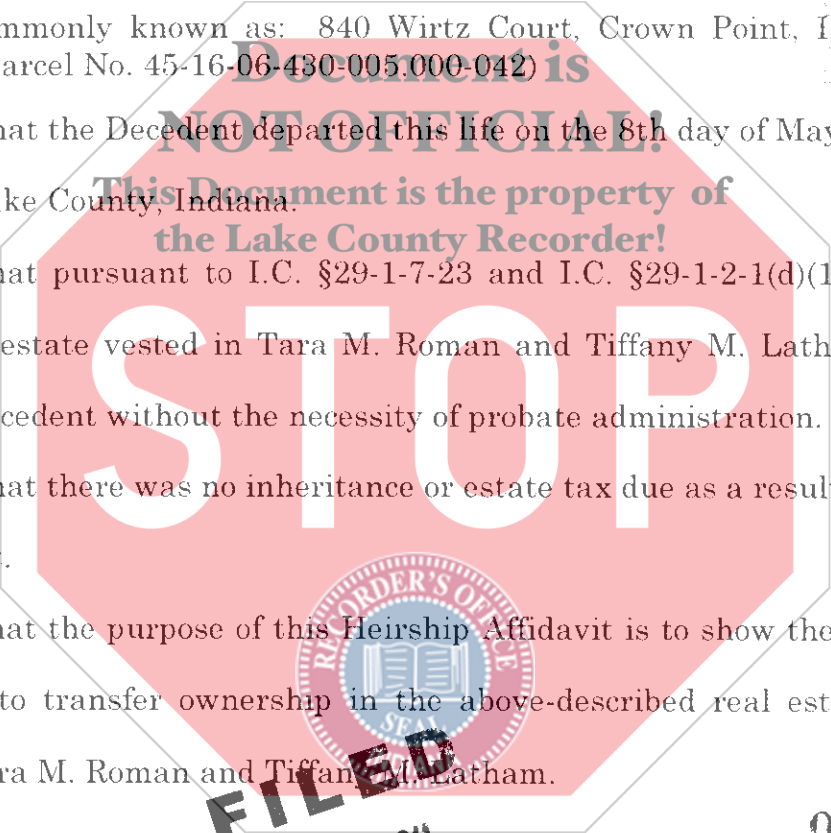
FILED
SEP 29 2011
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

Tara M. Roman
TARA M. ROMAN

028997

2011
053918

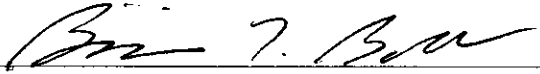
2011 SEP 29 PM 2:17



AMOUNT \$ 16⁰⁰
CASH _____ CHARGE _____
CHECK # 17562
OVERAGE _____
COPY _____
NON-COM ✓
CLERK 135

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

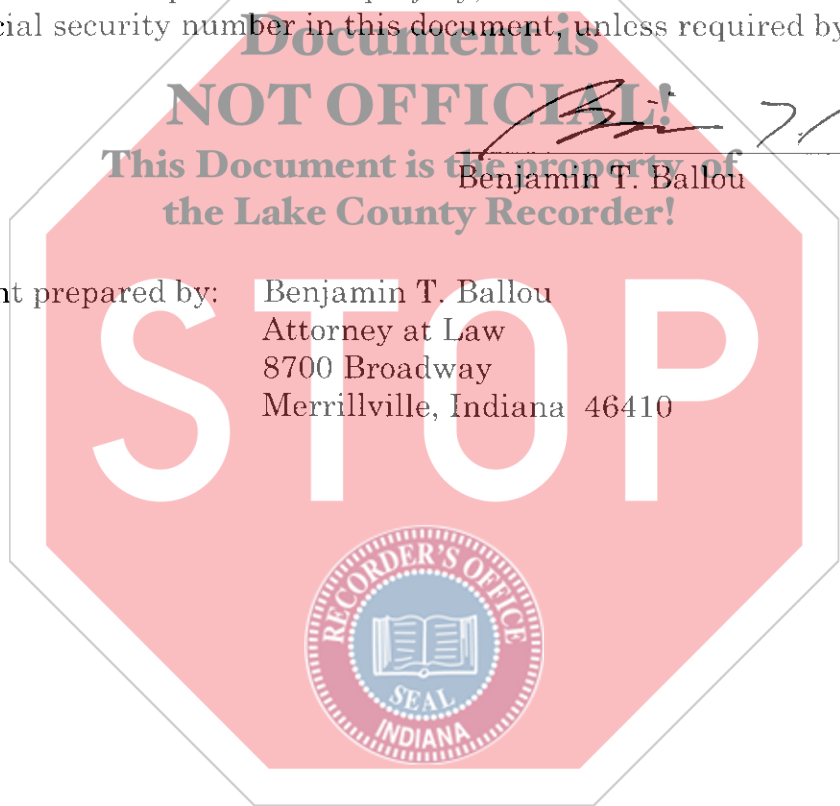
Before me, the undersigned, a Notary Public in and for said County and State, this 29th day of September, 2011, personally appeared Tara M. Roman and acknowledged the execution of the foregoing Heirship Affidavit. In witness whereof, I have hereunto subscribed my name and affixed my official seal.


Benjamin T. Ballou, Notary Public
Resident of Lake County

My Commission Expires:
November 21, 2015



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.



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17,007-1



**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

Local No **001450**

EDR No **00000198544**

State No **020549**

1. Decedent's Legal Name (First, Middle, Last) JACQUELINE MARIE ROMAN				1a. Maiden Name (If female) CHABE		2. Sex FEMALE	3. Time Of Death 03:15 AM	4. Date Of Death (Month/Day/Year) 05/08/2011	
5. Social Security Number 309-58-6162		6a. Age - Yrs 60	6b. Under 1 Year Months	6c. Under 1 Month Days	6d. Under 1 Day Hours	6e. Under 1 Hour Minutes	7. Date of Birth (Month/Day/Year) 01/12/1951		8. Birthplace (City and State or Foreign Country) EAST CHICAGO, IN
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival			10a. If Death Occurred Somewhere Other Than A Hospital <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)				
11. Facility Name (If Not Institution, Give Street and Number) ST ANTHONY MEDICAL CENTER OF CROWN POINT									
12. City Or Town, State, And Zip Code CROWN POINT, IN, 46307					13. County Of Death LAKE		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
15. Surviving Spouse's Name			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation BUSINESS OWNER		17. Kind Of Business/Industry EMPLOYMENT STAFFING	
18. Residence - State INDIANA		18a. County LAKE			18b. City Or Town CROWN POINT				
18c. Street And Number 840 WIRTZ COURT						18d. Apt. No.	18e. Zip Code 46307	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED		20. Decedent Of Hispanic Origin NOT HISPANIC			21. Decedent's Race White				
22. Father's Name (First, Middle, Last) JOHN CHABE				23. Mother's Name (First, Middle, Last) LILLIAN R CHABE			23a. Mother's Maiden Last Name BURKE		
24. Informant's Name TARA M ROMAN		24a. Relationship To Decedent DAUGHTER		24b. Mailing Address (Street And Number, City, State, Zip Code) 840 WIRTZ COURT, CROWN POINT, IN 46307					
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify):			25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) CALUMET PARK CEMETERY-CREMATORY		25c. Location - City, Town, And State MERRILLVILLE, IN				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility CALUMET PARK FUNERAL CHAPEL, 7535 TAFT STREET, MERRILLVILLE, IN 46410					27a. Funeral Home License Number: FH10400032		
27b. Signature Of Indiana Funeral Service Licensee: SHERRY L WILLIAMS, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee): FD20700074			
28. Part I. Enter The <u>Chain Of Events</u> - 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 The Etiology. 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. RESPIRATORY FAILURE, MULTIORGAN SYSTEM FAILURE, MI, ARF, SEPTIC SHOCK, HEMATOMA, UTI Approximate Interval: Onset To Death 3 DAYS 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. _____ C. _____ D. _____									
Part II. Enter Other <u>Significant Conditions Contributing to Death</u> But Not Resulting In The Underlying Cause Given In Part I DIABETES, CORONARY ARTERY DISEASE, HYPOTHYROIDISM						29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		32. If Female: <input checked="" type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At Time Of Death <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 <input type="checkbox"/> Unknown If Pregnant Within The Past Year		33. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined			
34. Date Of Injury (Month/Day/Year)		35. Time Of Injury		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wedding Reception) LAKE COUNTY HEALTH DEPARTMENT		37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No.	38d. Zip Code		
39. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)			
41. Signature, Of Person Certifying Cause Of Death: CHRISTINA ARAYA, BY ELECTRONIC SIGNATURE						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: CHRISTINA ARAYA, 2050 MAIN STREET, SUITE F, CROWN POINT, IN 46307						44. License Number 01066369A		45. Date Certified 05/10/2011	
46. Additional Funeral Service Provider:						47. *Alias:			
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): MAY 11 2011			
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)									