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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2012 042606

2012 JUN 27 PM 1:55

MICHELLE R. FAJMAN
RECORDER

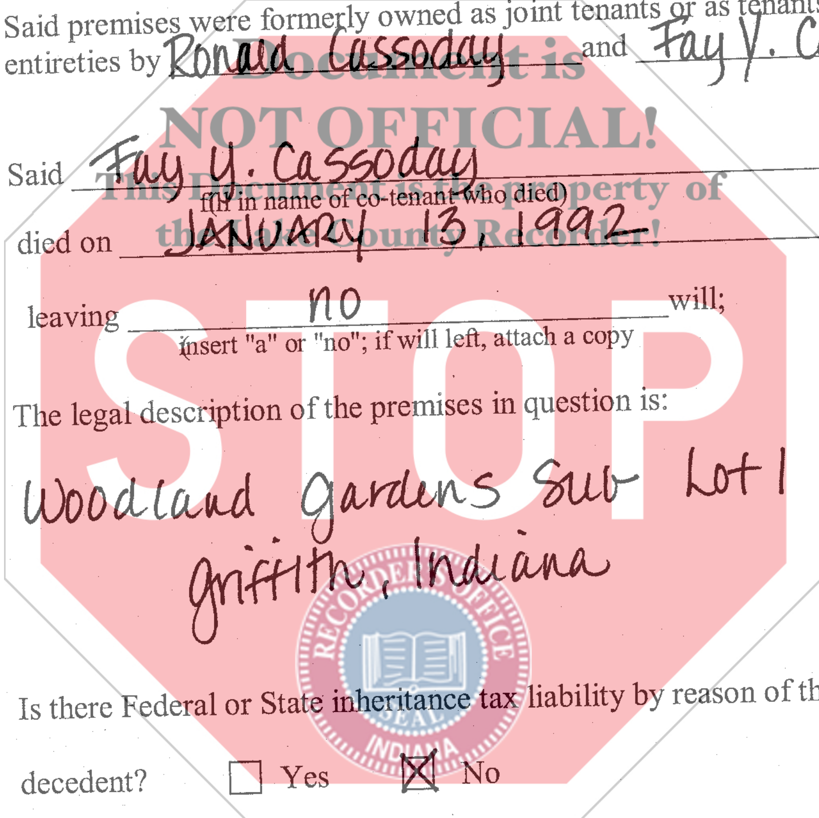
SURVIVORSHIP AFFIDAVIT

On this 6/22/12 (insert date) before me personally appeared Ronald Cassoday

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:

2. Affiant is owner
   (state interest of affiant in the above premises as "owner"," son of owner", etc.



3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Ronald Cassoday and Fay Y. Cassoday;

4. Said Fay Y. Cassoday (fill in name of co-tenant who died)
   died on JANUARY 13, 1992
   leaving no will;
   (insert "a" or "no"; if will left, attach a copy

5. The legal description of the premises in question is:

   Woodland Gardens Sub Lot 1
   Griffith, Indiana

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JUN 27 2012

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? ☐ Yes ☒ No

   If yes, then estimated taxes due are $ ____________

   The taxes due are ☐ paid or ☐ unpaid..

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7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? No

(If answer is "Yes" , identify the divorce proceedings: ____________________):

8. Affiant's relationship to the deceased was husband

Signature [signature]

Printed Name Ronald Cassoday

Address: 413 S. Broad St.
Griffith, IN 46319

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the Lake County Recorder!
STOP

Subscribed and sworn to before me by the affiant

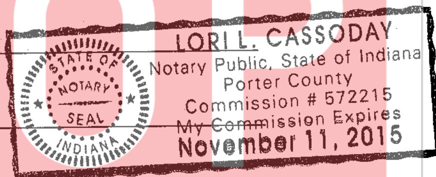
This 6/22/12
(insert date)

[signature]
Notary Public

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: Lori L. Cassoday
As agent for Professional Title Services

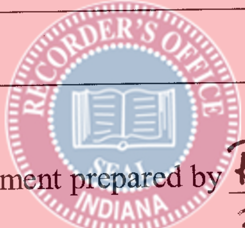
Printed Name ____________

My County of Residence is: ____________



In the State of ____________

My Commission Expires ____________



This instrument prepared by Ronald Cassoday
3442 W STRD 16
Rensselaer, IN 47978

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 096-92 State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): FAY Y. CASSODAY
2. SEX: FEMALE
3a. TIME OF DEATH: 7:55 AM
3b. DATE OF DEATH (Month, Day, Yr): JANUARY 13, 1992
4. SOCIAL SECURITY NUMBER:
5a. AGE—Last Birthday (Years): 45
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Apr. 12, 1946
7. BIRTHPLACE (City and State or Foreign Country): Staples, Minnesota
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL: [X] Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: MUNSTER
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Ronald Cassoday
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Home Maker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Griffith
13d. STREET AND NUMBER: 413 S. Broad
13e. ZIP CODE: 46319
13f. INSIDE CITY LIMITS: ☐ No [X] Yes
13g. ON A FARM?: [X] No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No ☐ 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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Joseph Kleist
19. MOTHER'S NAME (First, Middle, Maiden Surname): Ariel Nordenskjold

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Ronald Cassoday
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 413 S. Broad Griffith, Indiana
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): January 16, 1992 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrilville, Indiana
22a. EMBALMER'S NAME: Edgar Gleim
22b. EMBALMER'S LICENSE NO.: FDO 1016173
23. WAS DEATH REPORTED TO CORONER?: [X] No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FDO 1014511
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

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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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Cardio pulmonary Arrest	Seconds
DUE TO (OR AS A CONSEQUENCE OF): b.	Metastatic Carcinoma Lung	Months
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

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

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.
JAN 15 1992
Alexander S. Williams, MD
LAKE COUNTY HEALTH COMMISSIONER

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):
[X] 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: John A. Hoehn [signature]
29c. MEDICAL LICENSE NO.: 00872
29d. DATE SIGNED (Month, Day, Year): JANUARY 14, 1992
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): JOHN A. HOEHN, D.O. 2001 U.S. 41 SCHERERVILLE, INDIANA 46375

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams, MD
32. DATE FILED (Month, Day, Year): January 15, 1992

CORONER USE ONLY

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.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1