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**AFFIDAVIT OF SURVIVORSHIP**

ON THIS 18<sup>th</sup> day OF December, 2012, personally appeared Helen T. Cross, the affiant, who being duly sworn her upon oath, did say that:

- 1. Affiant resides at the address given below Affiant's signature;
- 2. Affiant is joint owner of the premises located at 613 Kane Street, Hammond, Indiana, and described below;
- 3. Said premises were formerly owned as tenants by the entireties by Kenneth Lavern Cross and Helen T. Cross.
- 4. Said Kenneth Lavern Cross died intestate on the 24<sup>th</sup> day of November, 1999.
- 5. The legal description of the said premises in question is:

Lot 28 in Block 3, as marked and laid down on the recorded plat of Louis E. Hohman's Addition to the Town, now City of Hammond, in Lake County, Indiana, as the same appears of record in Plat Book 1, page 56, in the Recorder's Office of Lake County, Indiana  
 Parcel No.: 45-02-36-429-028.000-023

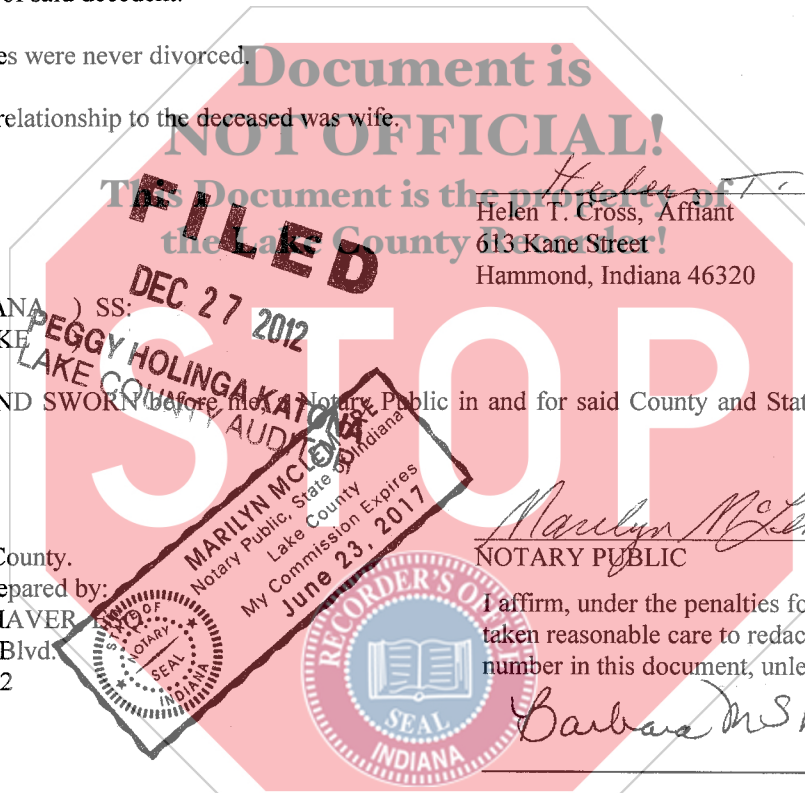
- 6. To the best of affiant's knowledge, there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent.
- 7. The parties were never divorced.
- 8. Affiant's relationship to the deceased was wife.

2012 092090

2012 DEC 28 AM 9:35

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

MICHAEL J. JAMMAN  
RECORDER

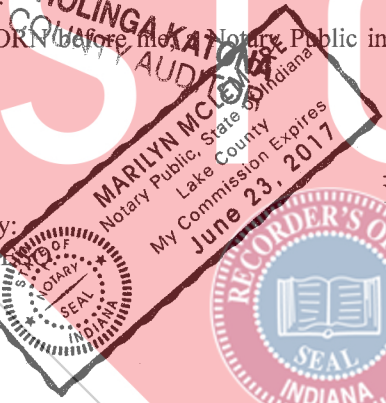


*Helen T. Cross*  
 Helen T. Cross, Affiant  
 613 Kane Street  
 Hammond, Indiana 46320

STATE OF INDIANA )  
COUNTY OF LAKE )

SUBSCRIBED AND SWORN before me, Notary Public in and for said County and State, this 18<sup>th</sup> day of December, 2012.

Resident of Lake County.  
 This instrument prepared by:  
 BARBARA M. SHAVER  
 9013 Indianapolis Blvd.  
 Highland, IN 46322  
 219/838-9200



*Marilyn McClellan*  
 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.

*Barbara M. Shaver*

**Return To:** Barbara M. Shaver, 9013 Indianapolis Blvd., Highland, IN 46322  
**Send Tax Bills To:** Helen T. Cross, 613 Kane Street, Hammond, IN 46320

016239

AMOUNT \$ 14  
 CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
 CHECK # 5251  
 OVERAGE \_\_\_\_\_  
 COPY \_\_\_\_\_  
 NON-COM   
 CLERK RA

E

\* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 933

CERTIFICATE OF DEATH

State Date Issued Nov. 29, 1999 Hammond Health Commissioner

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) <b>Kenneth L. Cross</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>07:06P.M.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>November 24, 1999</b>
4. SOCIAL SECURITY NUMBER <b>308-18-7803</b>	5a. AGE—Last Birthday (Years) <b>78</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day Yr.) <b>July 29, 1921</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Hammond, IN</b>	8a. WAS DECEASENT A U.S. VETERAN? <b>YES</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) <b>St. Margaret Mercy Hospital North</b>		9c. CITY, TOWN OR LOCATION OF DEATH <b>Hammond</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Helen Tomko</b>	12a. DECEASENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Meat Cutter</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Grocery Stores</b>
13a. RESIDENCE—STATE <b>IN</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Hammond</b>		13d. STREET AND NUMBER <b>613 Kane St.</b>
13e. ZIP CODE <b>46320</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEASENT 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) <b>White</b>
17. DECEASENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5 + ) <b>0</b>		18. FATHERS NAME (First, Middle, Last) <b>Loys Cross</b>		
19. MOTHERS NAME (First, Middle, Maiden Surname) <b>Ruby Daniels</b>		20a. INFORMANT'S NAME (Type/Print) <b>Helen Cross</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>613 Kane St. Hammond, IN 46320</b>		20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) <b>November 29, 1999 Elmwood Cemetery</b>		21c. LOCATION—City or Town, State <b>Hammond, IN</b>
22a. EMBALMERS NAME <b>John T. Noble</b>		22b. EMBALMERS LICENSE NO. <b>9000031</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John T. Noble</i>		24b. LICENSE NUMBER (or Licensee) <b>9000031</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns-Kish FH #3002819 5840 Hohman Hammond, IN 46320</b>	
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) a. <b>Diphtheria Toxicity</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>Sepsis</b> 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				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I.				
27. WAS DECEASENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>N/A</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>	
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>Steve A. D.</i>		29c. MEDICAL LICENSE NO. <b>01263</b>	29d. DATE SIGNED (Month, Day, Year) <b>Nov. 11-29-99</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>S. Kim D.O. 5454 Hohman Avenue Hammond Indiana 46320</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Shanley D. Premuda M.D.</i>				32. DATE FILED (Month, Day, Year) <b>November 29, 1999</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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.		

