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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 016981

2013 MAR -6 AM 10:43

MICHAEL B. BROWN
RECORDER

Send Tax Bills to:
1636-1640 Kennedy Avenue
Schererville, IN 46375

Parcel Number: 45-11-16-126-012.000-036

SURVIVORSHIP AFFIDAVIT

Jo AQnn Goff, being first duly sworn upon oath, states as follows:

1. Affiant is the daughter of Olen G. Sills ("Decedent"), and is qualified to make this Affidavit.
2. Decedent died a resident of Lake County, Indiana, on October 17, 2011. A copy of Decedent's death certificate is attached as Exhibit A.
3. At the time of his death, Olen G. Sills and Geneva Sills were husband and wife, and were not legally separated.
4. At the time of his death, Decedent owned real estate, legally described as follows:
Part of the Northwest Quarter of Section 16, Township 35 North, Range Nine West of the Second P.M.; commencing at a point on the east line thereof 455.6 feet South of the Northeast Corner; thence West 200 feet; thence North 73 feet; thence West 200 feet; thence South 93 feet; thence East 400 feet; thence North 20 feet to the place of beginning, in Lake County, Indiana.
Commonly known as 1636-1640 Kennedy Avenue, Schererville, IN ("Real Estate").
5. The assets of Decedent's gross estate, as defined for federal estate tax purposes, were either not sufficient to necessitate the payment of federal estate tax or such federal estate tax has been paid.
6. Any and all inheritance taxes relating to the Real Estate, if any, have been duly paid.

COMMUNITY TITLE COMPANY
FILE NO 133712 LAKECO 11081

#15
FILED CM
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 PEGGY HOLINGAKATONA
 LAKE COUNTY AUDITOR

7. Geneva Sills, surviving spouse of Decedent and surviving joint owner of the Real Estate, pursuant to Indiana law, is the owner of all right, title, and interest to the Real Estate.

Dated this 15 day of February, 2013.

Jo Ann Goff
Jo Ann Goff

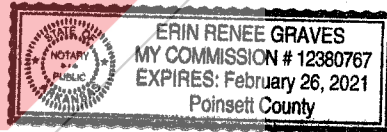
STATE OF ARKANSAS)
) SS:
COUNTY OF POINSETT)

Before me the undersigned, a Notary Public for the State of Indiana, personally appeared Jo Ann Goff and acknowledged the execution of this instrument this 15th day of February, 2013.

My Commission Expires: 2/26/2021 Erin Renee Graves
County of Residence: Poinsett ERIN RENEE GRAVES, Notary Public
(printed name)

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. Kathryn D. Schmidt

This instrument prepared by: Kathryn D. Schmidt, Burke Costanza & Carberry LLP
9191 Broadway, Merrillville, IN 46410





INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 003207

EDR No 00000224570

State No 045743

| | | | | | | | | |
|---|----------------------------|--|---|--|---|---|---|---|
| 1. Decedent's Legal Name (First, Middle, Last) OLEN G SILLS | | | | 1a. Maiden Name (if female) | | 2. Sex MALE | 3. Time Of Death 02:25 PM | 4. Date Of Death (Month/Day/Year) 10/17/2011 |
| 5. Social Security Number 429-28-1085 | 6a. Age - Yrs 89 | 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) 09/25/1922 | 8. Birthplace (City and State or Foreign Country) PLEASANT PLAINS, AR | |
| 9. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 10. If Death Occurred In A Hospital: <input 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 checked="" type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify) | | | |
| 11. Facility Name (If Not Institution, Give Street and Number) REGENCY PLACE OF DYER | | | | | | | | |
| 12. City Or Town, State, And Zip Code DYER, IN, 46311 | | | | 13. County Of Death LAKE | | 14. Marital Status At Time Of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | |
| 15. Surviving Spouse's Name GENEVA SILLS | | | 15a. (If Wife) Give Maiden Last Name SMITH | | 16. Decedent's Usual Occupation MILLWRIGHT | | 17. Kind Of Business/Industry STEEL | |
| 18. Residence - State INDIANA | | 18a. County LAKE | | 18b. City Or Town DYER | | 18d. Apt. No. | 18e. Zip Code 46311 | 18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 18c. Street And Number 1640 KENNEDY AVENUE | | 19. Decedent's Education 8TH GRADE OR LESS | | 20. Decedent Of Hispanic Origin NOT HISPANIC | | 21. Decedent's Race White | | |
| 22. Father's Name (First, Middle, Last) ORIS SILLS | | | 23. Mother's Name (First, Middle, Last) UNAVAILABLE UNAVAILABLE | | | 23a. Mother's Maiden Last Name UNAVAILABLE | | |
| 24. Informant's Name TIM SILLS | | 24a. Relationship To Decedent SON | | 24b. Mailing Address (Street And Number, City, State, Zip Code) 5701 HIGHWAY 163, HARRISBURG, AR 72432 | | | | |
| 25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input 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) CHAPEL LAWN MEMORIAL GARDENS | | | 25c. Location - City, Town, And State SCHERERVILLE, IN | | | |
| 26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 27. Name And Complete Address Of Funeral Facility CHAPEL LAWN FUNERAL HOME AND MEMORIAL GARDENS, 8178 S. CLINE AVE., SCHERERVILLE, IN 46375 | | | | | 27a. Funeral Home License Number: FH19900051 | |
| 27b. Signature Of Indiana Funeral Service Licensee: LEONARD G. GREGORCZYK, BY ELECTRONIC SIGNATURE | | 27c. License Number (Of Licensee): FD08800305 | | | 28. Part I. Enter The Chain Of Events - 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. <u>FAILURE TO THRIVE SYNDROME</u> | | Due to (Or As A Consequence Of): | | Approximate Interval: Onset To Death 4 WEEKS | | |
| 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. <u>ORGANIC BRAIN SYNDROME</u> | | Due to (Or As A Consequence Of): | | 1 YEAR | | |
| | | C. <u>COMPENSATED HEART FAILURE</u> | | Due to (Or As A Consequence Of): | | 6 MONTHS | | |
| | | D. | | | | | | |
| Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. | | | | | | 29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown | | 32. If Female: <input 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, Wooded Area) | | 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: FRED ADLER, 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: FRED ADLER, 800 MAC ARTHUR BLVD STE 2, MUNSTER, IN 46321 | | | | | | 44. License Number 01019251A | | 45. Date Certified: 10/19/2011 |
| 46. Additional Funeral Service Provider: | | | | | | 47. *Akas: | | |
| 48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE | | | | | | 49. For Registrar Only - Date Filed (Month/Day/Year): OCT 20 2011 | | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | | | | | | | |

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.



CERTIFICATE
State Form 26217 (R2/7-09)

333948

THE ABOVE IS A TRUE COPY OF THE RECORD ON FILE
WITH THE INDIANA STATE DEPARTMENT OF HEALTH.

SEP - 5 2012

Not valid unless machine signed with multi-colored ribbon.
It is unlawful to reproduce this record.