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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 018252

2013 MAR 12 AM 10:59

MICHAEL B. BROWN
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Julie M. McKenzie, of adult age, being first duly sworn, upon deposes and says:

That Julie M. McKenzie, is the Wife of , deceased, who died on April 9, 1999 a resident of Lake County, Indiana.

That affiant and said decedent, as husband and wife acquired title to the following described real estate located in Lake County, IN to wit:

SEE ATTACHED LEGAL DESCRIPTION

and hereinafter sometimes called "the Real Estate" for convenience by a Deed from Piper Enterprises, Inc. recorded July 1, 1977 as Document No. 415186 in the Office of the Office of the Recorder of Lake County, Indiana.

That affiant and said decedent were legally married to one another at this time and that said marital relationship between them continued unbroken by divorce, dissolution or annulment of marriage, until the death of said decedent on the date hereinabove indicated.

That all debts, funeral expenses, and expenses of last illness of the decedent have been fully paid and satisfied. That the gross value of he estate of said decedent, including all jointly held property, all gifts made in the contemplation of death, or made within the three years next preceding said death, together with the value of all above described, plus the proceeds of all insurance on the life of said decedent, was an amount which was not subject to a Federal Estate Tax.

That the purpose of this affidavit is to induce the Auditor of the County in which said real estate is located to change the tax records, and, if necessary to show the title to the above described real estate in the name of Julie M. McKenzie, surviving spouse of the decedent.

And further affiant sayeth not this 19th day of February, 2013.

*Julie M. McKenzie by
Robyn McKeague her
attorney-in-fact*
Julie M. McKenzie by Robyn McKeague, her attorney-in-fact

State of Indiana, County of Lake ss:

Subscribed and sworn to before me, the undersigned, a Notary Public in and for the County and State aforesaid, this 19th day of February, 2013.

WITNESS my hand and Notarial Seal.

My Commission Expires:



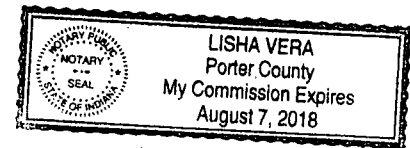
Lisha Vera
Signature of Notary Public

Printed Name of Notary Public

Notary Public County and State of Residence

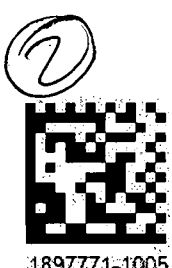
This instrument was prepared by:
Debra A. Guy, Attorney-at-Law, IN #24473-71 MI #P69602
202 S. Michigan Street, Ste. 300, South Bend, IN 46601

Property Address:
9617 Olcott Avenue, Saint John, IN 46373



File No.: 13-2623

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. Lisha Vera (Type or Print Name)



HOLD FOR MERIDIAN TITLE
13-2623

FILED
MAR 07 2013

150
MT
RM

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

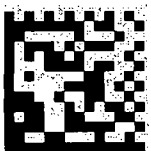
11162

LEGAL DESCRIPTION

Lot Numbered Twenty-five (25) in Candlelight Trails 1st Addition to the Town of St. John, as per plat thereof, recorded in Plat Book 44, Page 135, in the Office of the Recorder of Lake County, Indiana.

Tax ID Number(s):
22-12-0066-0026

45-11-32-252-008.000-035



1897771-1005

THIS DOCUMENT NOT VALID UNLESS
Stamped on Reverse Side and
Embossed with Raised Seal of
Porter County

PORTER COUNTY
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT
155 Indiana Ave.
Suite 104
Valparaiso, IN 46383

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

1. DECEASED—NAME (First, Middle, Last) Thomas Elmo McKenzie		2. SEX Male	3a. TIME OF DEATH 6:42 A.M.	3b. DATE OF DEATH (Month, Day, Year) April 9, 1999
4. SOCIAL SECURITY NUMBER 407-40-0694	5a. AGE—Last Birthday (Years) 67	5b. UNDER 1 YEAR Months: Days: Hours: Minutes:	6. DATE OF BIRTH (Mo., Day, Yr.) November 12, 1931	7. BIRTHPLACE (City and State or Foreign Country) Flat Gap, Kentucky
8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1955	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> EP/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) VNA Mary Bartz Hospice Center		9c. CITY, TOWN, OR LOCATION OF DEATH Valparaiso	9d. COUNTY OF DEATH Porter	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Julie M. Marsh	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). Chemical Engineer		12b. KIND OF BUSINESS/INDUSTRY Paint Co
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION St John	13d. STREET AND NUMBER 9617 Olcott Ave	
13e. ZIP CODE 46373	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT 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) White
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 4 College (11-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Ora McKenzie		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Belva Boggs		20. INFORMANT'S NAME (Type/Print) Julie M. McKenzie		
20a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9617 Olcott Ave St John, Indiana 46373		20b. Relationship Wife		
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) April 12, 1999 Chapel Lawn Memorial Gardens		21c. LOCATION—City or Town, State Schererville, Indiana
22a. EMBALMER'S NAME Henry Blake		22b. EMBALMER'S LICENSE NO. EDO 1019406	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mulloney</i>		24b. LICENSE NUMBER (of Licensee) EDO 1007176	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Homes Inc 1920 Hart St Dyer, Indiana 46311 FH83001	
26. PART I. Enter the disease, 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. cerebral vascular accident DUE TO (OR AS A CONSEQUENCE OF): 4 weeks Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				
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	
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) as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER X <i>George A. Seberke, M.D.</i>		29c. MEDICAL LICENSE NO. 07001581	29d. DATE SIGNED (Month, Day, Year) 4-10-99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 9430 Wicken Ave. St. John IN. 46373				
31. HEALTH OFFICER'S SIGNATURE <i>George A. Seberke, M.D.</i>				32. DATE FILED (Month, Day, Year) April 12, 1999
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		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.				