3

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 019805

2013 MAR 15 AM 8:55

MICHAEL B. BROWN
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

I, Thomas W. Allison, being duly sworn, states as follows:

1. I am over the age of eighteen (18) and suffer from no disability which would render my testimony incompetent.

2. I am a current Trustee of the THOMAS AND DONNA ALLISON LIVING TRUST, dated January 17, 2000. Said Trust is the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

LOT SEVENTEEN (17), BLOCK TWO (2), FIFTH STREET ESTATES FIRST ADDITION TO THE TOWN OF HIGHLAND, AS SHOWN IN PLAT BOOK 31, PAGE 57, IN LAKE COUNTY, INDIANA.

Grantee Address/Commonly known as: 9032 Hess Drive
Highland, Indiana 46322

3. The decedent, Donna Faye Allison, acquired a life estate in said real estate by deed of conveyance on the 16th day of November, 2000, and recorded in the Office of the Lake County Recorder as Document No. 2000 088813.

4. The decedent reserved a life estate in said real estate until her death on the 27th day of January, 2004. See attached Death Certificate for Donna Faye Allison.

5. The gross value of the estate of the decedent as determined for the purpose of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return; therefore, the decedent's estate was not subject to Federal Estate Tax.

Thomas W. Allison
Thomas W. Allison, Affiant

15.00
6507
RV

FILED

MAR 15 2013

21768

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Thomas W. Allison, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 3rd day of March, 2013.

My commission expires: 09/06/2014

Signature: _____
Gary P. Bonk
Resident of: Lake County, Indiana

"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."

/s/Gary P. Bonk

This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800

7

ATTENTION ESTATE: The Social Security # is ...ing requested by this state agency in order to ...rsue its statutory responsibility. Disclosure is ...luntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 289-04 State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): DONNA FAYE ALLISON
2. SEX: FEMALE
3a. TIME OF DEATH: 9:48 AM
3b. DATE OF DEATH (Month, Day, Yr.): JANUARY 27, 2004
4. *SOCIAL SECURITY NUMBER: 315-28-5972
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR Months Days:
5c. UNDER 1 DAY Hours Minutes:
6. DATE OF BIRTH (Mo, Day, Yr): NOVEMBER 6,1929
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
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 ☒ 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): THOMAS W. ALLISON
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: HIGHLAND
13d. STREET AND NUMBER: 9032 HESS DRIVE
13e. ZIP CODE: 46322
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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): 12th; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): CHARLES STUMPF
19. MOTHER'S NAME (First, Middle, Maiden Surname): MILDRE DRAGOZET

INFORMANT

20a. INFORMANT'S NAME (Type/Print): THOMAS W. ALLISON
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9032 HESS DRIVE, HIGHLAND, INDIANA 46322
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): FEBRUARY 2, 2004 ST. JOHN CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, INDIANA
22a. EMBALMER'S NAME: DEAN G. WAGNER
22b. EMBALMER'S LICENSE NO.: 8800057
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Dean G Wagner
24b. LICENSE NUMBER (of Licensee): 8800057
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN-PRUZIN FUNERAL HOME FH1020037, 14 KENNEDY AVE., SCHERERVILLE, IN. 46375

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. Sepsis
DUE TO (OR AS A CONSEQUENCE OF)
b. Acute Abdomen
DUE TO (OR AS A CONSEQUENCE OF)
c. Lung CA
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 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): ☒ 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: Mark A Feldner MD
29c. MEDICAL LICENSE NO.: 01035622A
29d. DATE SIGNED (Month, Day, Year): JANUARY 29, 2004
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARK FELDNER, M.D. 9660 WICKER AVENUE ST. JOHN, INDIANA 46373

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan M Bart D.O.
32. DATE FILED (Month, Day, Year): January 30, 2004

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.

SDH06-004, State Form 10110 (R5/1-00)