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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2013 019805

2013 MAR 15 AM 8:55

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

MICHAEL D. BROWN  
RECORDER

**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:

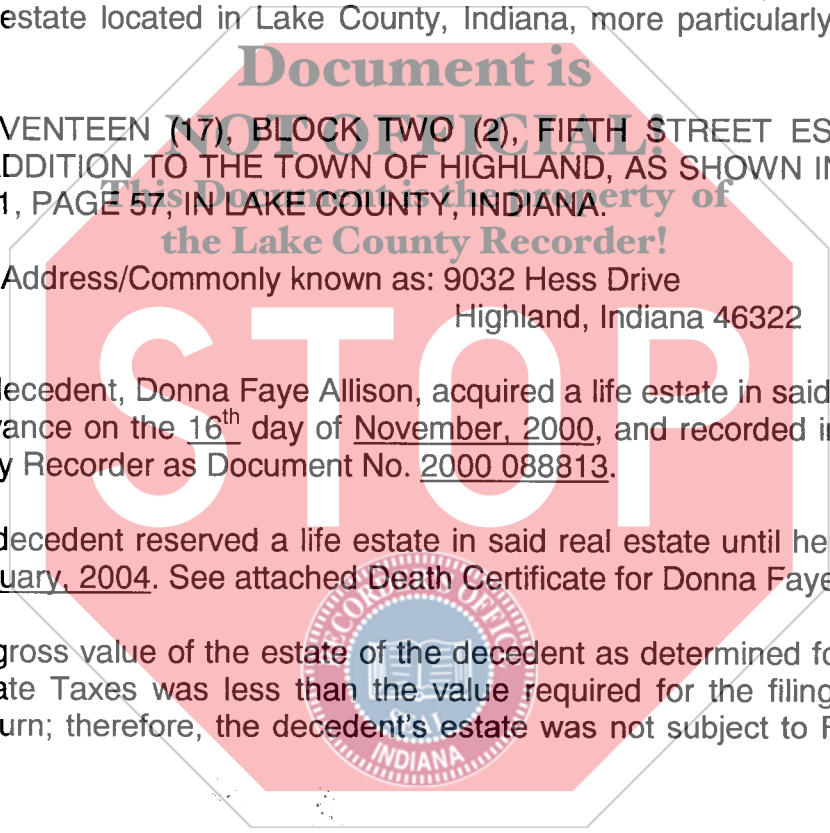
LOT SEVENTEEN (17), BLOCK TWO (2), FIFTH STREET ESTATES FIRST ADDITION TO THE TOWN OF HIGHLAND, AS SHOWN IN PLAT BOOK 31, PAGE 57, IN LAKE COUNTY, INDIANA.

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 16<sup>th</sup> 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 27<sup>th</sup> 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

**FILED**

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MAR 15 2013


PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

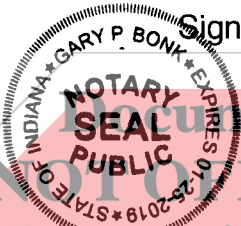
STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

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 3<sup>rd</sup> day of March, 2013.

My commission expires: 09/06/2014

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



**NOTICE!**  
This Document is the property of  
the Lake County Recorder's Office

"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



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

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

Local No. 289-04

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

INFORMANTS

INFORMANT

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>DONNA FAYE ALLISON</b>			2 SEX <b>FEMALE</b>		3a TIME OF DEATH <b>9:48 AM</b>		3b DATE OF DEATH (Month, Day, Yr.) <b>JANUARY 27, 2004</b>	
4 *SOCIAL SECURITY NUMBER <b>315-28-5972</b>		5a AGE—Last Birthday (Years) <b>74</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) <b>NOVEMBER 6, 1929</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>EAST CHICAGO, INDIANA</b>	
8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			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>THE COMMUNITY HOSPITAL</b>				9c CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>		9d COUNTY OF DEATH <b>LAKE</b>		
10 MARITAL STATUS (Specify) <b>MARRIED</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>THOMAS W. ALLISON</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOME MAKER</b>		12b KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>		
13a RESIDENCE—STATE <b>INDIANA</b>		13b COUNTY <b>LAKE</b>	13c CITY, TOWN, OR LOCATION <b>HIGHLAND</b>		13d STREET AND NUMBER <b>9032 HESS DRIVE</b>			
13e ZIP CODE <b>46322</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>WHITE</b>	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		
18 FATHER'S NAME (First, Middle, Last) <b>CHARLES STUMPF</b>				19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>MILDRE DRAGOZET</b>				
20a INFORMANT'S NAME (Type/Print) <b>THOMAS W. ALLISON</b>			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9032 HESS DRIVE, HIGHLAND, INDIANA 46322</b>			20c Relationship <b>HUSBAND</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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>FEBRUARY 2, 2004 ST. JOHN CEMETERY</b>			21c LOCATION—City or Town, State <b>HAMMOND, INDIANA</b>			
22a EMBALMER'S NAME <b>DEAN G. WAGNER</b>		22b EMBALMER'S LICENSE NO. <b>8800057</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean G. Wagner</i>		24b LICENSE NUMBER (of Licensee) <b>8800057</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>SOLAN-PRUZIN FUNERAL HOME FH1020037 14 KENNEDY AVE., SCHERERVILLE, IN. 46375</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. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Acute Abdomen</b> DUE TO (OR AS A CONSEQUENCE OF) <b>Lung CA</b> DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death						
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) <b>no</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>NO</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>Mark A Feldner M.D.</i>			29c MEDICAL LICENSE NO. <b>01035622A</b>	29d DATE SIGNED (Month, Day, Year) <b>JANUARY 29, 2004</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>MARK FELDNER, M.D. 9660 WICKER AVENUE ST. JOHN, INDIANA 46373</b>								
31 HEALTH OFFICER'S SIGNATURE <i>Susan J. Butts D.O.</i>						32 DATE FILED (Month, Day, Year) <b>January 30, 2004</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"/> 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.						