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STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

2013 022718

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 MAR 27 AM 10: 51

MICHAEL B. BROWN
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Comes now Scott Cooper, and upon being duly sworn does attest and say:

1. That the affiant is the son of Kenneth W. Cooper, and Ruth E. Cooper, deceased.

2. That Kenneth W. Cooper and Ruth E. Cooper, husband and wife, were the owners of real property located in Lake County, Indiana, more particularly described as:

   Lot No. Eight (8), in Block No. Three (3), as marked and laid down on the recorded plat of Country Club Estates Subdivision in the City of Hobart, Lake County, Indiana, as the same appears of record in Plat Book 20, page 41, in the Recorder's Office of Lake County, Indiana.

   Parcel No.: 45-09-30-332-018.000-018
   Commonly known as: 226 N. California, Hobart, IN 46342

3. That Kenneth W. Cooper and Ruth E. Cooper acquired the property during the term of their marriage.

4. That Kenneth W. Cooper died on the 18th day of October, 2002.

5. That Ruth E. Cooper died on the 25th day of August, 2012.

6. That Ruth E. Cooper became the fee simple owner of the property at the death of Kenneth W. Cooper

I affirm under the penalties for perjury that the foregoing statements are true.

Scott Cooper

Scott Cooper

STATE OF INDIANA)
COUNTY of LAKE)SS:

Subscribed and sworn to before me this 26 day of March, 2013.

Patricia A. Rees, Notary Public
Resident of Lake County

My Commission
Expires: 03/25/2018

001680

$13

I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

Patricia A. Rees

CK# 11801

This Instrument Prepared by: Patricia A. Rees, Attorney at Law, 5341 Central Ave., Portage, IN 46368 (219) 947-1692.

5 cc
2 vet
7 total

* **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.

Local No. 195-02

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
KENNETH W. COOPER	Male	7:11 AM M	October 18, 2002

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
306-09-5735	88			October 1, 1914	Hobart Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
YES	1946	HOSPITAL: [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER: [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Mary Medical Center	Hobart	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Ruth MacPherson	Foreman	Steel

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Hobart	226 N. California Street

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46342	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	White	Elementary/Secondary (0-12): 12	College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Chester Cooper	Stella Ryan

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Ruth Cooper	226 N. California Street, Hobart, IN 46342	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	Oct 22, 2002 Hobart Cemetery	Hobart IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FD01006463	[X] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
James J. Krause	FD01006463	Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

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. Subdural Hematoma	one week
DUE TO (OR AS A CONSEQUENCE OF)	b. Respiratory	one week
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last	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 IN PAST YEAR? POSTPARTUM? (Yes or no)	28. WAS AN AUTOPSY PERFORMED? (Yes or no)	29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	No

THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT
MAR 26 2013
LAKE COUNTY HEALTH OFFICER

CERTIFIER

29a. CERTIFIER (Check only one)

- [X] 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
George Abu-Aita MD	01038300	10/21/02

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): George Abu-Aita MD 9120 Connecticut Drive, Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan D Bryant M.D.

32. DATE FILED (Month, Day, Year):

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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 (R5/1-99)