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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 028379

2013 APR 22 AM 9:17

MICHAEL B. BROWN
RECORDER

Case # 920130829

SURVIVORSHIP AFFIDAVIT

Comes now Carol L. Banks, who being duly sworn upon his/her oath, deposes and says:

That, Carol L. Banks is the surviving spouse of Thomas R. Banks, deceased who died domiciled in Lake County, Indiana, on 11/05/2010.

That Thomas R. Banks and Thomas R. Banks acquired title to certain real estate as tenants by the entireties, said real estate being described as follows:

Lot 17 in West Point Acres, Unit 2 as shown in Plat Book 44 page 39, in the Office of the Recorder of Lake County, Indiana.

45-15-01-401-001.000-041

Affiant states that Carol L. Banks and Thomas R. Banks continued to live and cohabit together as husband and wife continuously from the date they took title to the above-described real estate, until the date of Thomas R. Banks's death.

Affiant states that the total assets of said estate, including the proceeds of life insurance policies and real and personal property, were not sufficient to subject the estate to Federal Estate Tax and that Indiana Inheritance Tax, if any, has been paid.

This affidavit is made for the purpose of maintaining a clear record of title to the above-described real estate and to induce the appropriate county authority of Lake County, Indiana, to transfer the above-described real estate to Carol L. Banks.

Executed: 4/8/13

Signature Carol L. Banks
Carol L. Banks



FILED
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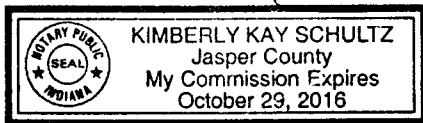
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

STATE OF INDIANA

COUNTY OF JASPER

Subscribed and sworn to before me, a Notary Public, in and for said County and State this 8 day of April, 2013.

Witness my hand and Notarial Seal on this 8 day of April, 2013.



Notary Public Kimberly Schultz
Resident of Jasper County
My Commission expires: 10/29/2016

Prepared by:
Austgen, Kuiper & Associates, PC, 130 N. Main St., Crown Point, IN 46307

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

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FN
CA

002044

FIDELITY NATIONAL
TITLE COMPANY
92013-0829



INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Local No. 3894-10

State No.

1. Decedent's Legal Name (First, Middle, Last) THOMAS R. BANKS				1a. Maiden Last Name (if Female) N/A		2. Sex M	3. Time Of Death 7:52 AM	4. Date Of Death (Month/Day/Year) NOVEMBER 5, 2010
5. Social Security Number	6a. Age Yrs 68	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) March 9, 1942	8. Birthplace (City And State Or Foreign Country) CROWN POINT, INDIANA	
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 checked="" 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 type="checkbox"/> Nursing Home/Long-Term Care Facility <input type="checkbox"/> Other (Specify)			
11. Facility Name (if Not Institution, Give Street And Number) ST. ANTHONY MEDICAL CENTER								
12. City Or Town, State, And Zip Code CROWN POINT, INDIANA 46307				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 CAROL BANKS			15a. (If Wife) Give Maiden Last Name FRALEY			16. Decedent's Usual Occupation MILLWRIGHT		17. Kind Of Business/Industry LOCAL 1043
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town CROWN POINT				
18c. Street And Number 10450 HANLEY ST.						18d. Apt. No. N/A	18e. Zip Code 46307	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19. Decedent's Education High school graduate or GED completed		20. Decedent Of Hispanic Origin No, not Spanish/Hispanic/Latino		21. Decedent's Race White				
22. Father's Name (First, Middle, Last) RANDALL C. BANKS				23. Mother's Name (First, Middle, Last) ISABEL BANKS		23a. Mother's Maiden Last Name MORTON		
24. Informant's Name CAROL BANKS		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 10450 HANLEY STREET CROWN POINT, INDIANA 46307				
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, INDIANA				
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 8178 S. CLINE AVENUE SCHERERVILLE, INDIANA 46376					27a. Funeral Home License Number: FH19900051	
27b. Signature Of Indiana Funeral Service Licensee: <i>Tara L. Wright</i>						27c. License Number (Of Licensee) FD20400058		
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. CARDIO-PULMONARY ARREST Due To (Or As A Consequence Of): B. CAD, SID CABG, AND Polymorphic Vent. Tachy - cat 1A Due To (Or As A Consequence Of): C. MIOM Due To (Or As A Consequence Of): D. _____ Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I Asthma, Pneumonia, Lung Cancer, AFB								
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No						30. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31. Did Tobacco Use Contribute To Death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input 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 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		37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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)		38c. Apt. No.		38d. Zip Code
38. Location Of Injury - State		38a. City Or Town		38b. Street & Number		39. Describe How Injury Occurred		
41. Signature Of Person Certifying Cause Of Death: <i>Zafar U. Khalid MD.</i>						42. Certifier (Check Only One) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Registered Health Officer		
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: ZAFAR U. KHALID MD 850 BROADWAY Merrillville IN 46410						44. License Number 01034369A		45. Date Certified 11-5-10
46. Additional Funeral Service Provider:						47. *Aka:		
48. Signature Of Local Health Officer: <i>Susan J. Best D.O.</i>				48. For Registrar Only - Date Filed (Month/Day/Year): November 9, 2010				