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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2013 052783

2013 JUL 18 AM 11:38

MICHAEL B. BROWN
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

Comes now, Mary Argenta de Bie, being first duly sworn upon her oath and states as follows:

1. The affiant is the daughter of the decedent, Dora Mae Argenta, and Successor Trustee of the Dora Mae Argenta Revocable Living Trust dated February 9, 2001.

2. That J. Marvin Argenta and Dora Mae Argenta owned the following described real estate located in Lake County, Indiana:

REXVILLE SUBDIV. L.13 BL.1.

Commonly known as: 5725 Approx Harrison Street, Merrillville, IN 46410.

Parcel No.: 45-12-04-401-005.000-030.

and

REXVILLE SUBDIV. L.14 BL.1.

Commonly known as: 5725 Approx Harrison Street, Merrillville, IN 46410.

Parcel No.: 45-12-04-401-004.000-030.

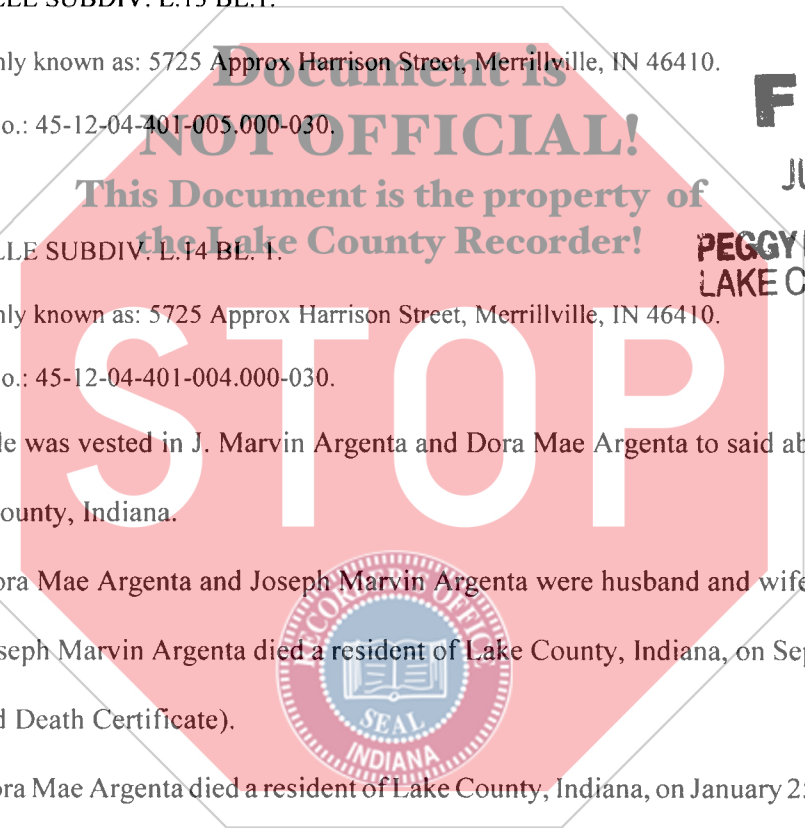
3. That title was vested in J. Marvin Argenta and Dora Mae Argenta to said above-described real estate located in Lake County, Indiana.

4. That Dora Mae Argenta and Joseph Marvin Argenta were husband and wife.

5. That Joseph Marvin Argenta died a resident of Lake County, Indiana, on September 3, 2001 (see attached Death Certificate).

6. That Dora Mae Argenta died a resident of Lake County, Indiana, on January 25, 2013 (see attached Death Certificate).

7. That Mary Argenta de Bie is the Successor Trustee of the Dora Mae Argenta Revocable Living Trust and the named Personal Representative for the Dora Mae Argenta Estate and therefore holds



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JUL 18 2013

PEGGY HOLINGAKATONA
LAKE COUNTY AUDITOR

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title and has dominion and control of the above-described real estate.

- 8. The affiant executes this Affidavit Of Survivorship to establish title to the above-described real estate.
- 9. That the gross value of the estate of the decedent was not subject to Federal Estate Tax or Indiana Inheritance Tax.

Mary Argenta de Bie

 Mary Argenta de Bie, Affiant

STATE OF INDIANA)
) SS:
 COUNTY OF LAKE)

SUBSCRIBED and sworn to before me, a Notary Public in and for said County and State, this 18th day of July, 2013.

My Commission Expires:
 June 25, 2017

(SEAL)



Brian P. Popp

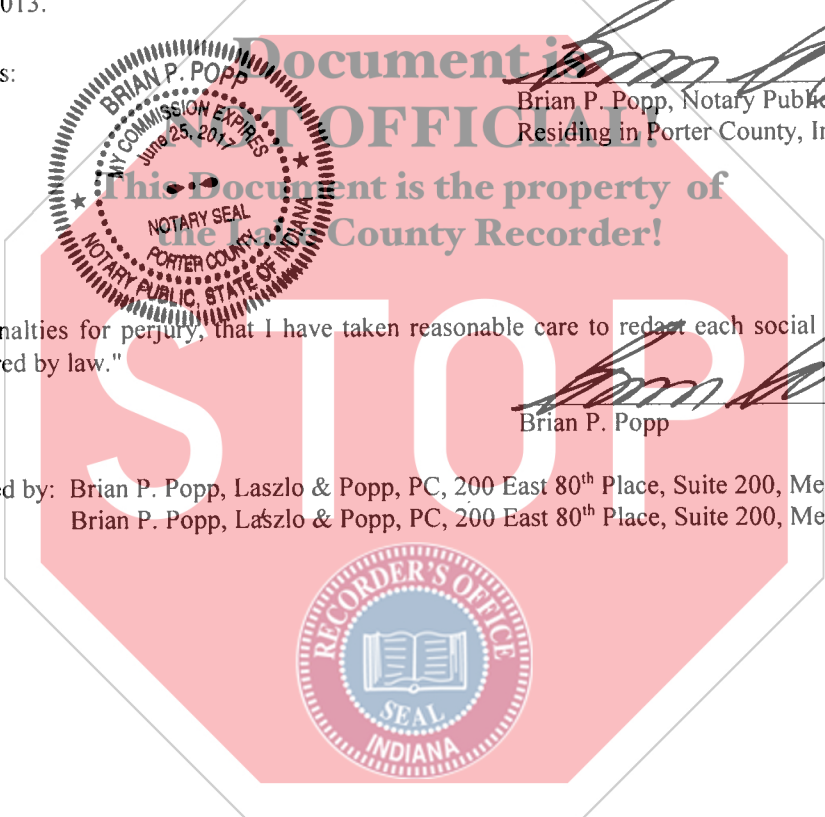
 Brian P. Popp, Notary Public
 Residing in Porter County, Indiana

"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."

Brian P. Popp

 Brian P. Popp

→ This instrument prepared by: Brian P. Popp, Laszlo & Popp, PC, 200 East 80th Place, Suite 200, Merrillville, IN 46410.
 Return affidavit to: Brian P. Popp, Laśzlo & Popp, PC, 200 East 80th Place, Suite 200, Merrillville, IN 46410.





INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Local No 000376

EDR No 00000304163

State No 004980

1. Decedent's Legal Name (First, Middle, Last) DORA MAE ARGENTA			1a. Maiden Name (If female) DAVIS			2. Sex FEMALE	3. Time Of Death 15:13	4. Date Of Death (Month/Day/Year) 01/25/2013			
5. Social Security Number 314-24-0648	6a. Age - Yrs 84	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) 08/15/1928		8. Birthplace (City and State or Foreign Country) OSAWATOMIE, KS			
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" 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) METHODIST HOSPITAL SOUTHLAKE MERRILLVILLE					13. County Of Death LAKE		14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown				
12. City Or Town, State, And Zip Code MERRILLVILLE, IN, 46410-7099			15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation HOMEMAKER		17. Kind Of Business/Industry OWN HOME				
15. Surviving Spouse's Name		15a. (If Wife) Give Maiden Last Name		16. Decedent's Usual Occupation HOMEMAKER		17. Kind Of Business/Industry OWN HOME					
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town MERRILLVILLE		18d. Apt. No.	18e. Zip Code 46410	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
18c. Street And Number 101 WEST 87TH AVENUE		19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White					
22. Father's Name (First, Middle, Last) LESTER W DAVIS			23. Mother's Name (First, Middle, Last) IVA DAVIS			23a. Mother's Maiden Last Name CAREY					
24. Informant's Name JAMES ARGENTA		24a. Relationship To Decedent SON		24b. Mailing Address (Street And Number, City, State, Zip Code) 3575 WEST 136TH LANE, CROWN POINT, IN 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) CALUMET PARK CEMETERY		25c. Location - City, Town, And State MERRILLVILLE, IN							
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	27. Name And Complete Address Of Funeral Facility GEISEN FUNERAL & CREMATION SERVICES, 7905 BROADWAY, MERRILLVILLE, IN 46410-5559					27a. Funeral Home License Number: FB40800005					
27b. Signature Of Indiana Funeral Service Licensee: RONALD J. MESARCH, BY ELECTRONIC SIGNATURE					27c. License Number (Of Licensee): FD01005912						
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. PEA ARREST			Due to (Or As A Consequence Of)			Approximate Interval Onset To Death: CURRENT		
Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last			B. PERIPHERAL VASCULAR DISEASE			Due to (Or As A Consequence Of)			FEB 01 2013 MONTHS		
			C. CHRONIC OBSTRUCTIVE PULMONARY DISEASE			Due to (Or As A Consequence Of)			MONTHS		
			D.								
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I					29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					30. Were Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" 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 checked="" 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	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)	37. Injury At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	38. Location Of Injury - State	38a. City Or Town	38b. Street & Number	38c. Apt. No.	38d. Zip Code
39. Describe How Injury Occurred											
40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)											
41. Signature Of Person Certifying Cause Of Death: JOSE LUIS AGUSTI, BY ELECTRONIC SIGNATURE					42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer						
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: JOSE LUIS AGUSTI, 60 VALPARAISO STREET, VALPARAISO, IN 46383					44. License Number 01061624A		45. Date Certified 01/31/2013				
46. Additional Funeral Service Provider:					47. *Akas:						
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE					49. For Registrar Only - Date Filed (Month/Day/Year): JAN 31 2013						

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

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.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1955-01

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) JOSEPH MARVIN ARGENTA		2 SEX Male	3a TIME OF DEATH 12:55 A.M.	3b DATE OF DEATH (Month Day, Yr.) September 3, 2001	
4 *SOCIAL SECURITY NUMBER 317-16-5962	5a AGE—Last Birthday (Years) 75	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr.) July 7, 1926	
7 BIRTHPLACE (City and State or Foreign Country) Bucknell, Iowa	8a WAS DECEDENT A U.S. VETERAN? Yes				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9b FACILITY NAME (If not institution, give street and number) 1800 W. 49th Avenue		9c CITY, TOWN OR LOCATION OF DEATH Gary /CAL. TWP.	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Dora Mae Davis	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Mason Contractor		12b KIND OF BUSINESS/INDUSTRY Self-Employed	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary/Calumet Township		13d STREET AND NUMBER 1800 W. 49th Avenue	
13e ZIP CODE 40408	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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 (10-12) 12 College (1-4 or 5 +)		18 FATHER'S NAME (First Middle, Last) August Argenta			
19 MOTHER'S NAME (First Middle, Maiden Surname) Minnie Nicoletto		20a INFORMANT'S NAME (Type/Print) Dora M. Argenta			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 W. 49th Avenue, Gary, Indiana 46408		20c 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) September 7, 2001 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Ronald J. Mesarch		22b EMBALMER'S LICENSE NO. FD01005912	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Ronald J. Mesarch</i>		24b LICENSE NUMBER (of Licensee) FD01005912	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410		
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. Restal Cancer with Metastases				Approximate Interval Between Onset and Death 32 months	
IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF)					
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		
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>Barbara L. Fuller, M.D.</i>		29c MEDICAL LICENSE NO. 01034701	29d DATE SIGNED (Month Day, Year) 9/05/01		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Barbara L. Fuller, M.D. 801 MacArthur Blvd. Ste 401 Munster, IN 4632					
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best</i>				32 DATE FILED (Month Day, Year) September 5, 2001	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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 THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. SEP 6 2001
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			