

3

AFFIDAVIT

On this December 10, 2013 before me personally appeared Debra L, Pampalone to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature:
2. Affiant is daughter of owners.
(state interest of affiant in the above premises as "owner", "son of owner", etc)
3. Said Steve Michael Miller aka Stephen M. Miller died on 7/6/2013
Said Doris E. Miller became incapacitated in December of 2009 and is residing in a nursing home.
4. The legal description of the premises in question is:

The West 1/2 of Lot 108 in Prairie View – Unit 2, an Addition to the City of Crown Point as per plat thereof, recorded in Plat Book 85, page 042 in the Office of the Recorder of Lake County Indiana.

45-14-09-252-017-000-042.
1707 Dogwood Drive Crown Point, IN 46307

5. Is there Federal or State inheritance tax liability by reason of the death of said decedent? Yes No

If yes, then estimated taxes due are \$ N/A

The taxes due are paid or unpaid..

FILED

DEC 16 2013

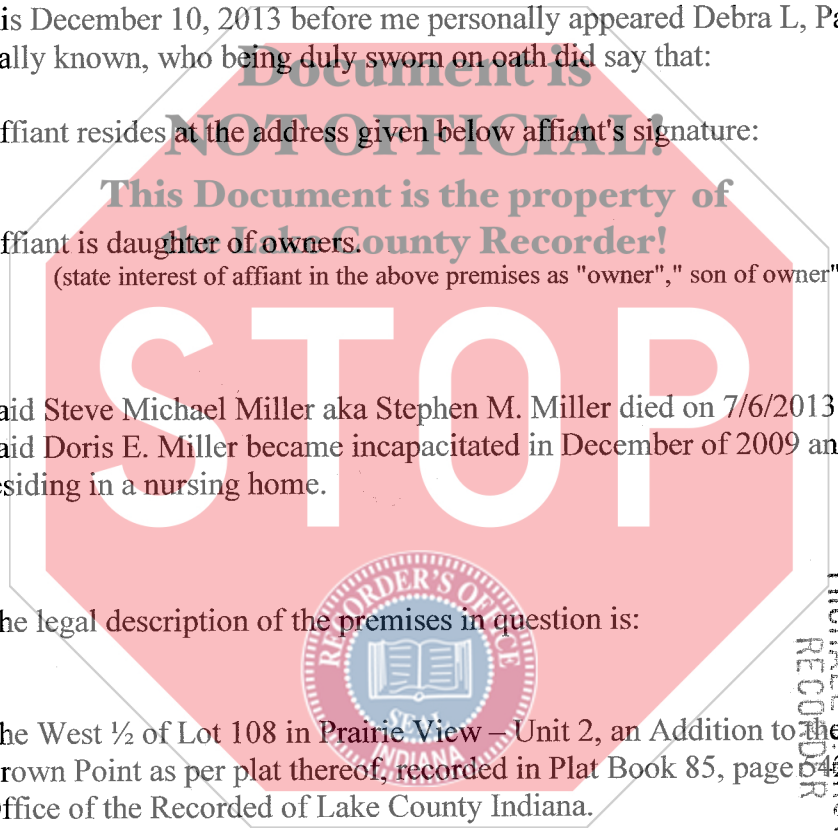
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

FIDELITY NATIONAL
TITLE COMPANY

93013-4058 ①

16951

Non-Conf. FN SF
#16



2013 092083

MICHAEL BROWN
RECORDER

2013 DEC 18 AM 8:54

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORDER

7. Affiant's relationship to the deceased was daughter

Signature: Debra L. Pampalone
Debra L, Pampalone

Subscribed and sworn to before me by the affiant

This 10th December, 2013
(insert date)

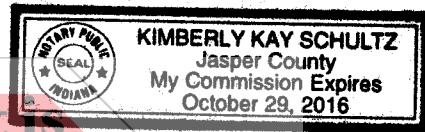
[Signature]
Notary Public

Kimberly Kay Schultz

My County of Residence is: Jasper

In the State of Indiana

My Commission Expires 10-29-16



"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."

[Signature]
KIM SCHULTZ





**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

Local No **000759**

EDR No **000000332035**

State No **031769**

1. Decedent's Legal Name (First, Middle, Last) STEVE MICHAEL MILLER				1a. Maiden Name (If female)		2. Sex MALE	3. Time Of Death 03:30 AM	4. Date Of Death (Month/Day/Year) 07/06/2013	
5. Social Security Number		6a. Age - Yrs 88	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) 04/19/1925		8. Birthplace (City and State or Foreign Country) GARY, IN
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 type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival			10a. If Death Occurred Somewhere Other Than A Hospital <input checked="" 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) VNA HOSPICE CENTER									
12. City Or Town, State, And Zip Code VALPARAISO, IN, 46383					13. County Of Death PORTER			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 DORIS EVELYN MILLER			15a. (If Wife) Give Maiden Last Name GRAY			16. Decedent's Usual Occupation PRINTER TYPE SETTER		17. Kind Of Business/Industry NEWSPAPER	
18. Residence - State INDIANA			18a. County LAKE			18b. City Or Town CROWN POINT		18d. Apt. No.	18e. Zip Code 46307
18c. Street And Number 1707 DOGWOOD DRIVE								18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education BACHELOR'S DEGREE (BA, AB, BS)			20. Decedent Of Hispanic Origin NOT HISPANIC			21. Decedent's Race White			
22. Father's Name (First, Middle, Last) FELIX MILLER				23. Mother's Name (First, Middle, Last) ANGELA MILLER			23a. Mother's Maiden Last Name MUCHA		
24. Informant's Name DEBRA PAMPALONE			24a. Relationship To Decedent DAUGHTER			24b. Mailing Address (Street And Number, City, State, Zip Code) 423 FORESTWOOD DRIVE, VALPARAISO, IN 46385			
25. Place Of Disposition									
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" 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) ANGELCREST CREMATORY				25c. Location - City, Town, And State VALPARAISO, IN			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility MOELLER FUNERAL HOME INC, 104 ROOSEVELT ROAD, VALPARAISO, IN 46383					27a. Funeral Home License Number: FH83006821		
27b. Signature Of Indiana Funeral Service Licensee: MARTIN L. MOELLER, BY ELECTRONIC SIGNATURE						27c. License Number (Of Licensee): FD01019561			
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. MYONEURAL DISORDER, UNSPECIFIED; CAUSE NEVER ESTABLISHED YEARS <small>Due to (Or As A Consequence Of):</small> B. SECONDARY DYSPHAGIA, FUNCTIONAL QUADRIPLEGIA, FAILURE TO THRIVE, YEARS <small>Due to (Or As A Consequence Of):</small> C. SMALL VESSEL CEREBROVASCULAR DISEASE YEARS <small>Due to (Or As A Consequence Of):</small> D. ADVANCED AGE								Approximate Interval: Onset To Death	
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I HISTORY OF PROSTATE AND COLON CANCER, CELL TYPES UNKNOWN TO ME, WITH NO RECURRENCE OF EITHER AFTER TREATMENT						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			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)		37c. Apt. No.		38d. Zip Code	
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: MICHAEL CARL WEISS, BY ELECTRONIC SIGNATURE						42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Heath Officer			
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: MICHAEL CARL WEISS, 2404 VALPARAISO STREET, VALPARAISO, IN 46383						44. License Number 01030965A		45. Date Certified 07/09/2013	
46. Additional Funeral Service Provider: MARIA L STAMP, VIA ELECTRONIC SIGNATURE						47. *Akas: STEPHEN M MILLER			
48. Signature of Local Health Officer: MARIA L STAMP, VIA ELECTRONIC SIGNATURE						49. For Registrar Only - Date Filed (Month/Day/Year): JUL 11 2013			

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)