

3

2014 011072

SURVIVORSHIP AFFIDAVIT

(Husband and wife)

1307325
STATE OF INDIANA) ③

) SS:

COUNTY OF LAKE)

Mary C. Sawyer, being first duly sworn upon oath, deposes and says:

1. That Thomas M. Sawyer died on June 21st, 2005 in Schererville, Indiana.
2. That Thomas M. Sawyer and Mary C. Sawyer were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
SEE ATTACHED LEGAL DESCRIPTION
3. Tax ID: 45-11-15-206-004-000-036
That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.
4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance n decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Mary C Sawyer

Subscribed and sworn to before me, a Notary Public, this 21st day of January, 2014

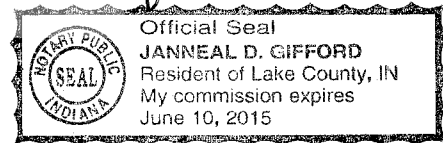
21033
FEB 21 2014
PEGGY HDLINGA KATONA
LAKE COUNTY AUDITOR

Commission Expiration: 06/10/2014

County of Residence: Lake

This instrument was prepared by: Mary C. Sawyer

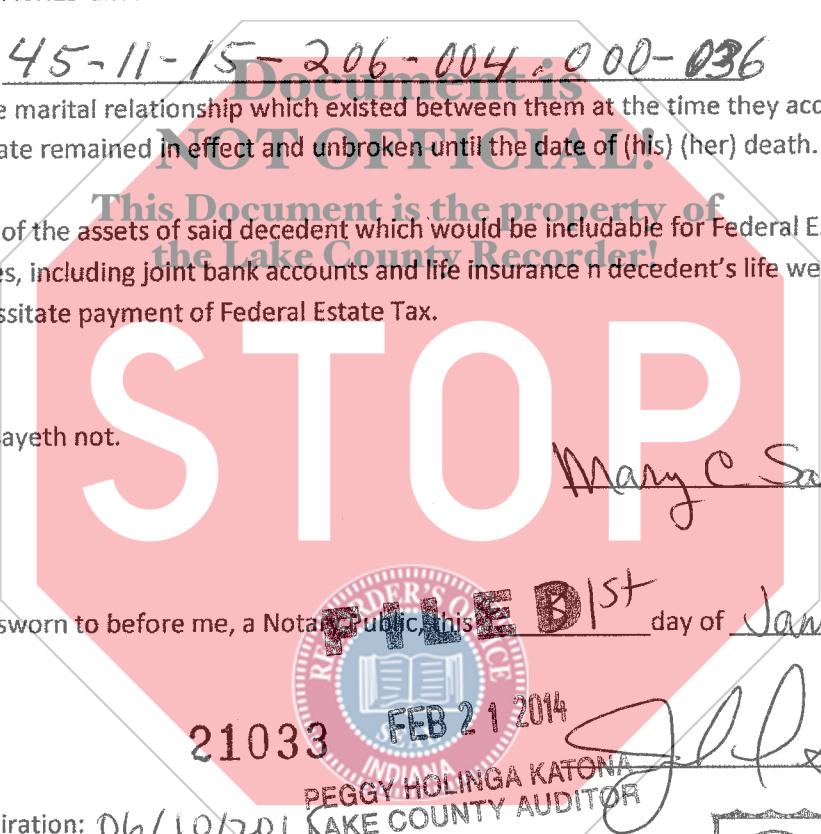
①



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. A. Burdick

CA
NON
CONF

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2014 FEB 21 10:35 AM
MARGARET BOSTON
RECORDER



CHIEF OF CLERK'S OFFICE

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to sue 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. 1706-05

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3 #45-11-15-206-004 000-036

TYPE/PRINT IN PERMANENT INK

DECEDENT

INFORMANT

FORMANT

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) THOMAS M. SAWYER				2. SEX MALE	3a. TIME OF DEATH 6:49 A M	3b. DATE OF DEATH (Month, Day, Yr.) JUNE 21, 2005
4. *SOCIAL SECURITY NUMBER 800-88-4000	5a. AGE—Last Birthday (Years) 58	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) SEPTEMBER 22, 1946	7. BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA	
8a. WAS DECEDENT A U.S. VETERAN? YES	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1972	HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		9a. PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) 437 GREGORY STREET			9c. CITY, TOWN, OR LOCATION OF DEATH SCHERERVILLE	9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) MARY RENDER	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) ROLLER		12b. KIND OF BUSINESS/INDUSTRY STEEL		
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION SCHERERVILLE	13d. STREET AND NUMBER 437 GREGORY STREET			
13e. ZIP CODE 46375	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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 (0-12) 1 College (1-4 or 5+) 1	
18. FATHER'S NAME (First, Middle, Last) RAYMOND SAWYER			19. MOTHER'S NAME (First, Middle, Maiden Surname) MARY E. THARP			
20a. INFORMANT'S NAME (Type/Print) MARY SAWYER			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 437 GREGORY STREET, SCHERERVILLE, IN 46375	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) JUNE 25, 2005 CHAPEL LAWN MEMORIAL GARDENS		21c. LOCATION—City or Town, State SCHERERVILLE, INDIANA		
22a. EMBALMER'S NAME MARC MOSQUEDA		22b. EMBALMER'S LICENSE NO. FD08800240		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) FD20400030		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME FAGEN MILLER FUNERAL HOME FH10200006 8580 WICKER AVENUE ST. JOHN, INDIANA 46373		
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. VENTRICULAR FIBRILLATION CORONARY ARTERY DISEASE						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) VENTRICULAR FIBRILLATION						THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT APR 26 2010
a. DUE TO (OR AS A CONSEQUENCE OF)						
b. DUE TO (OR AS A CONSEQUENCE OF)						
c. DUE TO (OR AS A CONSEQUENCE OF)						
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>[Signature]</i>				29c. MEDICAL LICENSE NO. 01029300	29d. DATE SIGNED (Month, Day, Year) 06.23.2005	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. SANDESAI 9307 CALUMET Munster, IN. 46321						
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					32. DATE FILED (Month, Day, Year) JUNE 24, 2005	
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	
34a. 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)			
I affirm, under the penalties for perjury, that I have taken reasonable care to reflect each Social Security number in this document, unless required by law.						
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT (Yes or no)				

EXHIBIT "A"

LOT 23 IN COUNTRY HILLS ESTATES AN ADDITION TO THE TOWN OF SCHERERVILLE, AS SHOWN IN PLAT BOOK 64, PAGE 6, LAKE COUNTY, INDIANA.

Property Address: 437 Gregory St., Schererville, IN 46375-2293

