

3

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2014 027193

2014 MAY 14 PM 1:38

STATE OF INDIANA )

) SS:

MICHAEL B. BROWN  
RECORDER

COUNTY OF LAKE )

**AFFIDAVIT OF SURVIVORSHIP**

I, Ingrid Wilkerson, being duly sworn, states as follows:

1. I am over the age of eighteen (18) and suffer from no disability which would render my testimony incompetent.

2. I am the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot 24, Lakewood Estates, Unit 3, an Addition to Lake County, Indiana.  
Plat Book 64, Page 49.

Grantee Address/Commonly known as: 16366 Morton Place  
Lowell, IN 46356

3. The decedent, Leonard K. Wilkerson, and myself acquired title as husband and wife to said real estate by deed of conveyance on the 16th day of November, 1988, and recorded in the Office of the Lake County Recorder as Document No. 009863.

4. The decedent and myself jointly held title to said real estate until the death of my husband Leonard K. Wilkerson on the 7th day of March, 2007, at which time I acquired title to the real estate as the surviving owner pursuant to property law. See attached Death Certificate for Leonard K. Wilkerson.

5. The gross value of the estate of the decedent as determined for the purpose of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return; therefore, the decedent's estate was not subject to Federal Estate Tax.

**FILED**

MAY 14 2014

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

*Ingrid Wilkerson*  
\_\_\_\_\_  
Ingrid Wilkerson, Affiant

012609

\$16  
CK#  
7042  
A

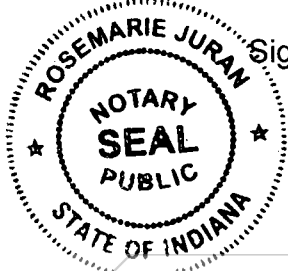
1 ref

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

Before me the undersigned, a Notary Public for Lake County, State of Indiana, personally appeared Ingrid Wilkerson, and, being first duly sworn by me upon oath, stated that the facts alleged in the foregoing instrument are true.

Signed and sealed this 13th day of May, 2014.

My commission expires: 09/06/2014

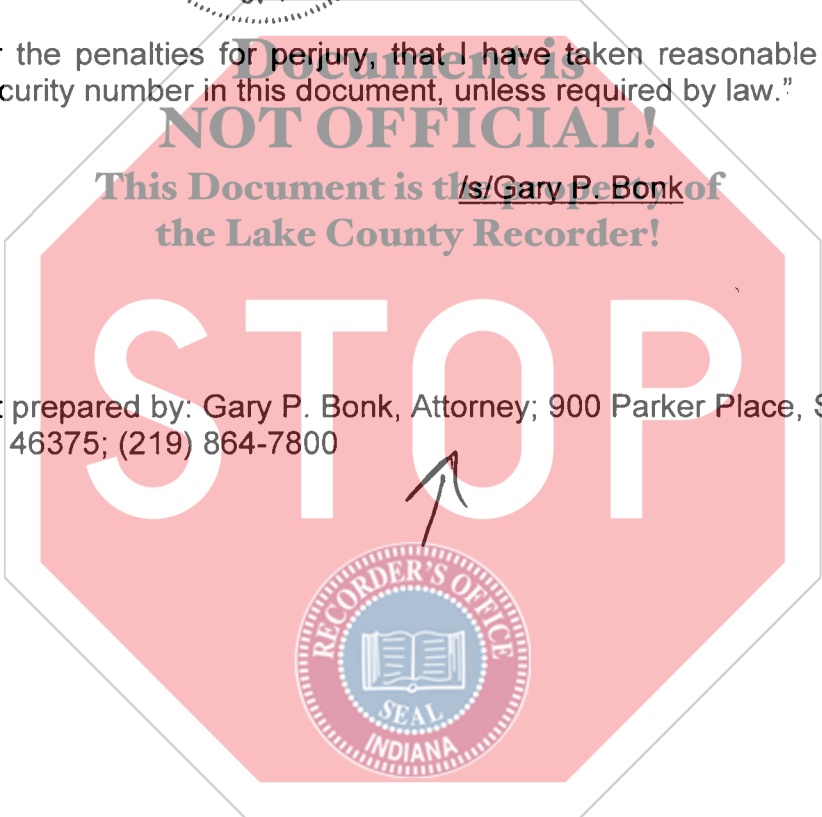


Signature: Rosemarie Juran  
Rosemarie Juran  
Resident of: Lake County, Indiana

"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."

**Document is NOT OFFICIAL!**

**This Document is the property of /s/ Gary P. Bonk of the Lake County Recorder!**



This instrument prepared by: Gary P. Bonk, Attorney; 900 Parker Place, Suite A, Schererville, IN 46375; (219) 864-7800

NON-ESTATE: The Social Security # is requested by this state agency in order to determine statutory responsibility. Disclosure is required and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

File No. 634-07

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Leonard K. Wilkerson</b>				2. SEX <b>Male</b>	3a. TIME OF DEATH <b>1:10 AM</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>March 7, 2007</b>	
4. *SOCIAL SECURITY NUMBER		5a. AGE—Last Birthday (Year) <b>73</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>July 27, 1933</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Brown Co. IN</b>	
8a. WAS DECEDENT A U.S. VETERAN? <b>YES</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>Unknown</b>	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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence					
9b. FACILITY NAME (If not institution, give street and number) <b>16366 Morton Pl.</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>Lowell</b>		9d. COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Ingrid Collins</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Operating Engineer</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Union</b>	
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN, OR LOCATION <b>Lowell</b>		13d. STREET AND NUMBER <b>16366 Morton Pl.</b>	
13e. ZIP CODE <b>46356</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>		
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) _____							
18. FATHER'S NAME (First, Middle, Last) <b>Clarence Wilkerson</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Oneida Stogsdill</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Ingrid E. Wilkerson</b>			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16366 Morton Pl., Lowell, IN 46356</b>			20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Entombment <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) <b>Mar 12, 2007</b> <b>Heritage Crematory</b>			21c. LOCATION—City or Town, State <b>Portage IN</b>		
22a. EMBALMER'S NAME: <b>N/A</b>		22b. EMBALMER'S LICENSE NO. <b>N/A</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Molly A. Miller</i>		24b. LICENSE NUMBER (of Licensee) <b>FD09200061</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Sheets Funeral Home FH83004277</b> <b>604 E. Commercial Ave. Lowell, IN 46356</b>			
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 injury failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <b>metastatic Prostate cancer</b> DUE TO (OR AS A CONSEQUENCE OF) _____ b. _____ DUE TO (OR AS A CONSEQUENCE OF) _____ c. _____ DUE TO (OR AS A CONSEQUENCE OF) _____ d. _____ 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) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>	
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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. <b>01030234</b>		
29d. DATE SIGNED (Month, Day, Year) <b>03 08 07</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Randall Hile MD 1020 E. Commercial Ave., Lowell, IN 46356</b>							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>					32. DATE FILED (Month, Day, Year) <b>MAR 09 2007</b>		
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH AND IS TO BE FILED WITH THE STATE ARCHIVES HOW INJURY OCCURRED							
33. MANNER OF DEATH <input checked="" 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. 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.				