

**SURVIVORSHIP AFFIDAVIT**

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

STATE OF INDIANA )  
                          )SS:  
COUNTY OF LAKE )

2014 048680

2014 AUG 13 AM 10:51

MICHAEL B. BROWN  
RECORDER

On this 4<sup>TH</sup> day of AUGUST, 2014, before me personally appeared LAONA F. ALLIE, who being duly sworn on his/her oath states the following:

1. That the Affiant is the owner of the real estate located in Lake County, State of Indiana, more particularly described as follows:

LOTS 31 AND 32, NORTH HALF OF BLOCK 25, DALECARLIA AS SHOWN IN PLAT BOOK 28 PAGE 9 IN LAKE COUNTY, INDIANA.

PARCEL NO: 45-19-01-353-002.000-007

2. That said premises were formerly owned as tenants by the entireties by HERMAN T. ALLIE AND LAONA F. ALLIE, husband and wife.

3. That said HERMAN T. ALLIE died on June 13, 2010, a resident of Lake County, Indiana, leaving no Will.

4. That by reason of the death of HERMAN T. ALLIE, there are no Federal Estate Taxes nor Indiana Inheritance Taxes due and payable by reason of the death of said Decedent.

5. That on the date of the death of HERMAN T. ALLIE said parties, namely, HERMAN T. ALLIE and LAONA F. ALLIE, were husband and wife, and have not been divorced.

FURTHER AFFIANT SAITH NOT.

NORTHWEST INDIANA TITLE  
152 WASHINGTON STREET  
LOWELL, IN 46356  
217-376-0100

*Laona F. Allie*  
LAONA F. ALLIE

**FILED**

STATE OF INDIANA )  
                          )SS:  
COUNTY OF LAKE )



25636

AUG 13 2014

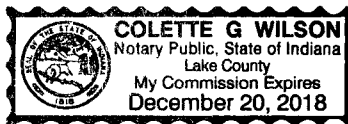
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

Before me, the undersigned, a Notary Public in and for said County and State, this 4<sup>TH</sup> day of AUGUST, 2014, personally appeared LAONA F. ALLIE and acknowledged the execution of the foregoing affidavit.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal.

My Commission Expires:

*Colette G. Wilson*  
Notary Public



County of Residence:

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.

RICHARD A. ZUNICA

AMOUNT \$ 14-  
THIS INSTRUMENT PREPARED BY: RICHARD A. ZUNICA, Attorney at Law  
CASH \_\_\_\_\_ CHARGE \_\_\_\_\_  
CHECK # 1999  
OVERAGE \_\_\_\_\_  
COPY \_\_\_\_\_  
NON-COM \_\_\_\_\_  
CLERK AA

162 Washington Street, Lowell IN 46356  
FILE NO. 14-20603

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



Local No. 2099-10

State No. \_\_\_\_\_

1 Decedent's Legal Name (First, Middle, Last) <b>Herman Allie</b>				1a Maiden Last Name (If Female) <b>N/A</b>		2 Sex <b>Male</b>	3 Time Of Death <b>9:40 p.m.</b>	4 Date Of Death (Month/Day/Year) <b>June 30, 2010</b>		
5 Social Security Number [REDACTED]		6a Age - Yrs <b>77</b>	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) <b>July 2, 1932</b>		8 Birthplace (City And State Or Foreign Country) <b>Schneider, Indiana</b>	
10 If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> <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 type="checkbox"/> Hospice Facility <input checked="" 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) <b>218 W. Lakeview Drive</b>										
12 City Or Town, State, And Zip Code <b>Lowell, Indiana 46356</b>					13 County Of Death <b>Lake</b>		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 <b>Laona Allie</b>			15a (If Wife) Give Maiden Last Name <b>Ogborn</b>		16 Decedent's Usual Occupation <b>Electrician</b>		17 Kind Of Business/Industry <b>Commercial Electric</b>			
18 Residence - State <b>Indiana</b>			18a County <b>Lake</b>		18b City Or Town <b>Lowell</b>					
18c Street And Number <b>218 W. Lakeview Drive</b>						18d Apt. No.	18e Zip Code <b>46356</b>		18f Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19 Decedent's Education <b>12 + 2</b>			20 Decedent Of Hispanic Origin <b>No</b>			21 Decedent's Race <b>White</b>				
22 Father's Name (First, Middle, Last) <b>Herman Allie</b>				23 Mother's Name (First, Middle, Last) <b>Virginia Allie</b>			23a Mother's Maiden Last Name <b>Olds</b>			
24 Informant's Name <b>Laona Allie</b>			24a Relationship To Decedent <b>Wife</b>		24b Mailing Address (Street And Number, City, State, Zip Code) <b>218 Lakeview Drive Lowell, IN 46356</b>					
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) <b>Midwest Crematory</b>			25c Location - City, Town, And State <b>La Porte, Indiana</b>					
26 Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27 Name And Complete Address Of Funeral Facility <b>Midwest Crematory 0678 E. Hupp Rd. La porte, IN 46350</b>						27a Funeral Home License Number <b>FH 10500015</b>		
27b Signature Of Indiana Funeral Service Licensee <i>[Signature]</i>						27c License Number (Of Licensee) <b>FD 08900012</b>				
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. <b>Metastatic large cell carcinoma</b> <span style="float:right">Approximate Interval - Onset: <b>6 months</b></span>										
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. <b>Large cell carcinoma</b> <span style="float:right">Approximate Interval - Onset: <b>7 months</b></span>										
C. _____ <span style="float:right">Approximate Interval - Onset: <b>JUL 26 2010</b></span>										
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 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 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 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 <i>[Signature]</i>						42 Certifier (Check Only One) <input 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 <b>Randall Hile M.D. 1020 E. Commercial Ave. Lowell, IN 46356</b>						44 License Number <b>01030234 A</b>		45 Date Certified <b>7/26/2010</b>		
46 Additional Funeral Service Provider:						47 *Akas				
48 Signature of Local Health Officer <i>[Signature]</i>						49 For Registrar Only - Date Filed (Month/Day/Year) <b>July 26, 2010</b>				