

2014 048801

2014 AUG 13 PM 3:06

State of Indiana)
) SS:
County of Lake)

MICHAEL D. BROWN
RECORDER

3

SURVIVORSHIP AFFIDAVIT

Erma M. McKinney, Keith A. McKinney, and Gail E. Merhalski (collectively "Joint Tenants"), as joint tenants with rights of survivorship and not as tenants in common, being duly sworn upon their oath, state as follows:

1) That Joint Tenants are the owner of the real estate located in Lake County, Indiana, commonly known as 205 West Joliet Street, Apt. 102, Schererville, Indiana 46375, and more particularly described as follows:

Apartment No. 102 in Building known as 205 Joliet Street, Schererville, Indiana in Le'Jardin Horizontal Property Regime, as per Declaration recorded December 19, 1985 as Document No. 833653 in the Office of the Recorder of Lake County, Indiana.

Together with an undivided 0.8691% interest in the common and limited common areas and facilities appertaining thereto.

Key No. 45-11-16-207-002.000-036.

2) That the affiants and Thomas D. McKinney were joint tenants with rights of survivorship, and not tenants in common, effective the 22 day of January 2003 and that said real estate remained in effect and the joint tenancy with rights of survivorship remained in effect and unbroken until the death of Thomas D. McKinney.

3) That Thomas D. McKinney died on the 26th day of January, 2003, at which time said real estate became the property of Joint Tenants and Joint Tenants continue to hold said real estate as joint tenants with rights or survivorship. See attached death certificate.

4) That the funeral expenses in connection with the death of said decedent have been paid in full.

5) That the required Federal Estate Tax Return and Indiana Inheritance Tax Returns have been filed and the assessed taxes paid.

6) That this affidavit is being filed to clarify the title to said real estate.

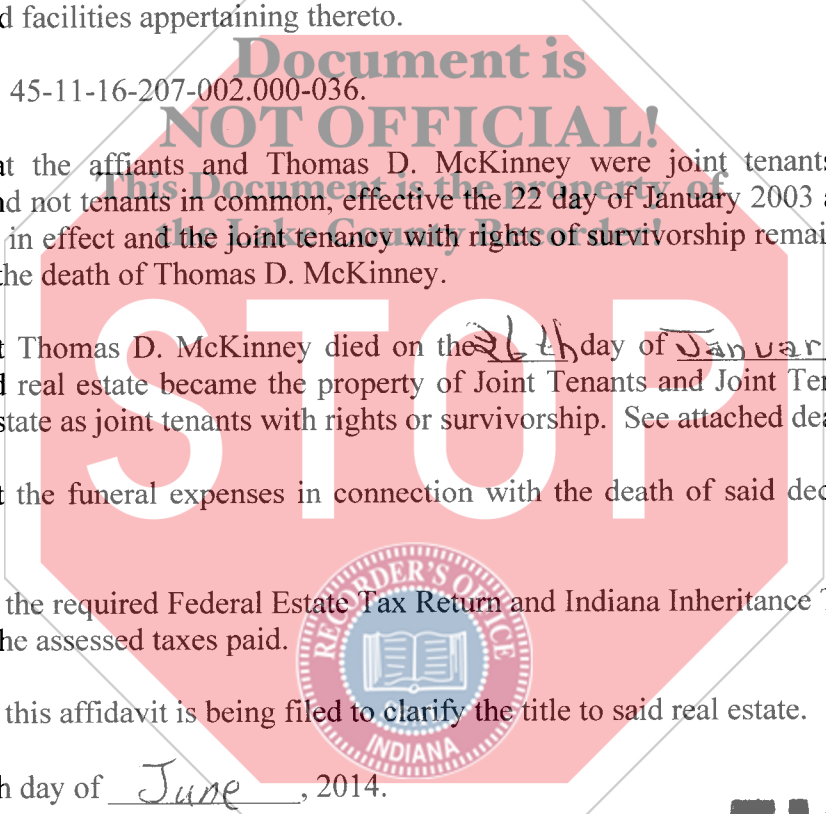
Dated this 29th day of June, 2014.

Erma M. McKinney
Erma M. McKinney 03535

FILED

AUG 13 2014

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR



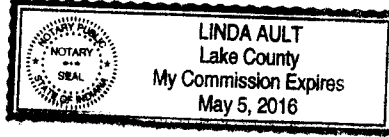
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Case
DN
NON-COR

Keith A. McKinney
Keith A. McKinney

Gail E. Merhalski
Gail E. Merhalski

Subscribed and sworn to before me, Notary Public in and for said County and State, this, 29th
day of June, 2014.

Linda L. Ault
Notary Public



Linda L. Ault
[Printed name of notary]

My commission expires: May 5, 2016

My county of residence: Lake

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.

Russell L. Ellis

This instrument was prepared by Russell L. Ellis.



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

Tracking No. 19159

Local No. 209-03

CERTIFICATE OF DEATH

State No.

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) THOMAS D. McKINNEY		2 SEX Male	3a TIME OF DEATH 9:10 PM	3b DATE OF DEATH (Month, Day, Yr) January 26, 2003	
4 SOCIAL SECURITY NUMBER [REDACTED]		5a AGE—Last Birthday (Years) 77	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) May 22, 1925		7 BIRTHPLACE (City and State or Foreign Country) Los Angeles, California			
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	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"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 205 W. JOLIET, APT. 102		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) ERMA AULT	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Director Stewardship Dept.		12b KIND OF BUSINESS/INDUSTRY FIRST BAPTIST CHURCH	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN, OR LOCATION SCHERERVILLE		13d STREET AND NUMBER 205 W. JOLIET, APT. 102	
13e ZIP CODE 46375	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <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 (0-12) 9 College (1-4 or 5+) 					
18 FATHER'S NAME (First Middle Last) THOMAS D. McKINNEY		19 MOTHER'S NAME (First Middle, Maiden Surname) OPAL CAIN			
20a INFORMANT'S NAME (Type/Print) ERMA M. McKINNEY		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 W. JOLIET, APT. 102, SCHERERVILLE, IN		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <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) Jan 31, 2003 Memory Lane Memorial Park		21c LOCATION—City or Town, State Schererville IN	
22a EMBALMER'S NAME HENRY J. BLAKE		22b EMBALMER'S LICENSE NO. FDO1019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FDO1013507		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BOCKEN FUNERAL HOME, INC. FH83002801 7042 KENEDY AVENUE, HAMMOND, IN	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cerebral Vascular Accident b. Hypertensive Cerebrovascular Disease c. Atherosclerotic Vascular Disease d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or No) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) No	
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Renal failure		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. 20000320	29d DATE SIGNED (Month, Day, Year) 1-28-03	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DENNIS STREETER, D.O. 119 E. 89TH AVENUE, MERRILLVILLE, IN 46410-					
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32 DATE FILED (Month, Day, Year) January 28 2003		
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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
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.			
<p>THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT</p> <p>JAN 28 2003</p> <p>RAISED SEAL AFFIXED</p>					