

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 059557

2015 SEP -2 AM 9:56

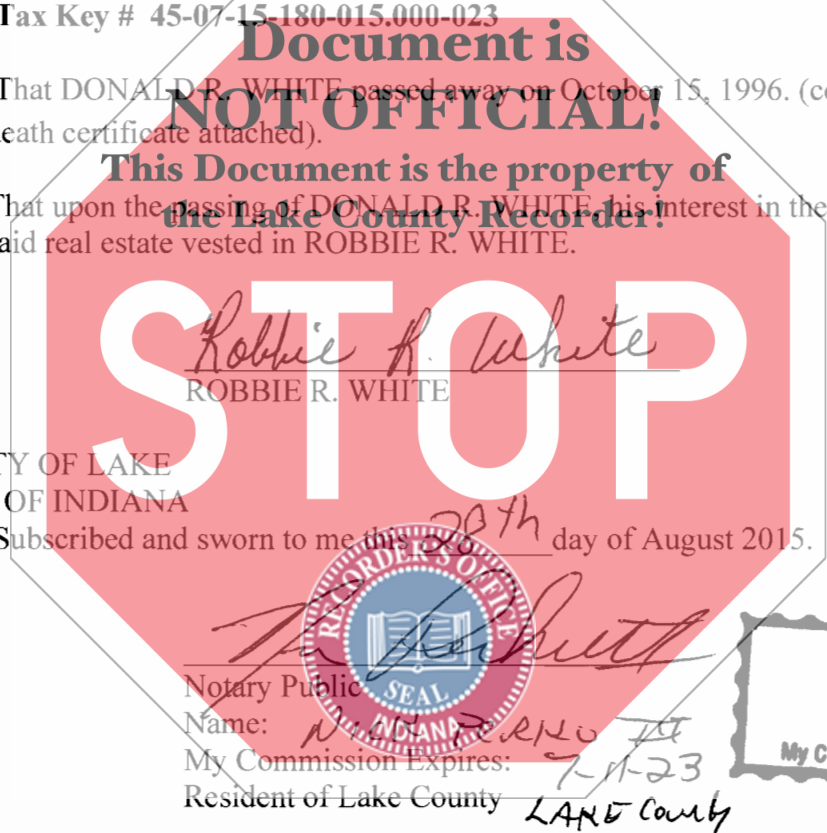
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MICHAEL B. BROWN
RECORDER

SURVIVORSHIP AFFIDAVIT

ROBBIE R. WHITE, being duly sworn upon her oath deposes and says:

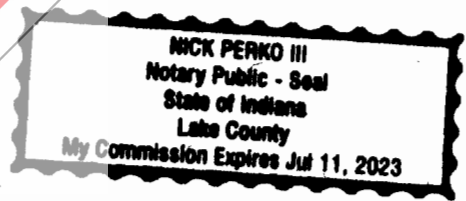
1. That she is the Wife of DONALD R. WHITE.
2. That ROBBIE R. WHITE held the following property, husband and wife, as tenants by the entireties in her name and DONALD R. WHITE:
TRI-STATE MANOR ADD. UNIT 2 ALL L. 15 BL. 4 recorded in the Office of the Recorder of Lake County, Indiana.
Commonly known as: 7633 Montana Ave. Hammond, Indiana 46323
Tax Key # 45-07-15-180-015.000-023
4. That DONALD R. WHITE passed away on October 15, 1996. (copy of death certificate attached).
5. That upon the passing of DONALD R. WHITE, his interest in the above said real estate vested in ROBBIE R. WHITE.



COUNTY OF LAKE
STATE OF INDIANA

Subscribed and sworn to me this 20th day of August 2015.

Nick Perko III
 Notary Public
 Name: NICK PERKO III
 My Commission Expires: 7-11-23
 Resident of Lake County LAKE County



This instrument was prepared by Nick A. Perko III, 3037 45th Ave. Highland, IN at the specific request of owner or representatives and is based solely on information supplied by one or more of those parties and without examination for accuracy. This preparer assumes no liability for any errors, inaccuracy or omissions in this instrument resulting from the information provided. The parties accept this disclaimer by owner's execution of this document.

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.

Nick A. Perko III
 NICK A. PERKO III

FILED

SEP 02 2015

JOHN E. PETALAS
LAKE COUNTY AUDITOR

13.00
M.E
#5031

21417

* 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.

Tracking No. 63525

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 833

State No.

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) Donald R. White		2 SEX male	3a TIME OF DEATH 10:36A M	3b DATE OF DEATH (Month, Day, Year) October 15, 1996	
4 *SOCIAL SECURITY NUMBER [REDACTED]	5a AGE—Last Birthday (Years) 62	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo, Day, Yr) May 9, 1934	
7 BIRTHPLACE (City and State or Foreign Country) Milburn West Virginia	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 checked="" type="checkbox"/> Inpatient OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) St. Margaret-Mercy Health Care Center		9c CITY, TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) married	11 SURVIVING SPOUSE (If wife, give maiden name) Robbie Herron	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Mill Mechanic	12b KIND OF BUSINESS/INDUSTRY steel manufacturing		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond	13d STREET AND NUMBER 7633 Montana Street		
13e ZIP CODE 46323	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 type="checkbox"/> No <input checked="" 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) <input checked="" type="checkbox"/> College (13-16 or S+) <input type="checkbox"/> 12		18 FATHER'S NAME (First, Middle, Last) Randolph White			
19 MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Hicks		20a INFORMANT'S NAME (Type/Print) Robbie White			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7633 Montana Street Hammond, Indiana 46323		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) October 17, 1996 Chapel Lawn Cemetery		21c LOCATION—City or Town, State Scherverville, Indiana	
22a EMBALMER'S NAME Raymond E. White		22b EMBALMER'S LICENSE NO. FD08700086	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR Raymond E. White		24b LICENSE NUMBER (of License) FD08700086	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Ruiper Funeral Home 9039 Kleinman Rd. Highland, Indiana 46322 FH83007500		
26 PART I Enter the disease, injuries, or complications that caused the death in the center 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. Ventricular fibrillation b. myocardial infarct c. Hypertensive cardiovascular disease d. Immediate					
PART II Other significant conditions—Conditions contributing to death but not previously listed in Part I. Insulin dependent diabetes mellitus					
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) n/a		
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 [Signature]		29c MEDICAL LICENSE NO. 01018592	29d DATE SIGNED (Month, Day, Year) Oct 16 1996		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) DR JERALD E. SMITH MD 7905 CABINET AVE. MUNSTER, INDIANA 46321					
31 HEALTH OFFICER'S SIGNATURE [Signature]			32 DATE FILED (Month, Day, Year) OCT 18 1996		
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) SEP 01 1995	34b TIME OF INJURY AT WORK? (Yes or no)	34c DESCRIBE HOW INJURY OCCURRED	
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State) [Signature]			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (If yes, specify driver-passenger, pedestrian, etc.)			



RAISED SEAL AFFIXED