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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 063103

2015 SEP 15 AM 9:27

MICHAEL B. BROWN
RECORDER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SURVIVORSHIP AFFIDAVIT

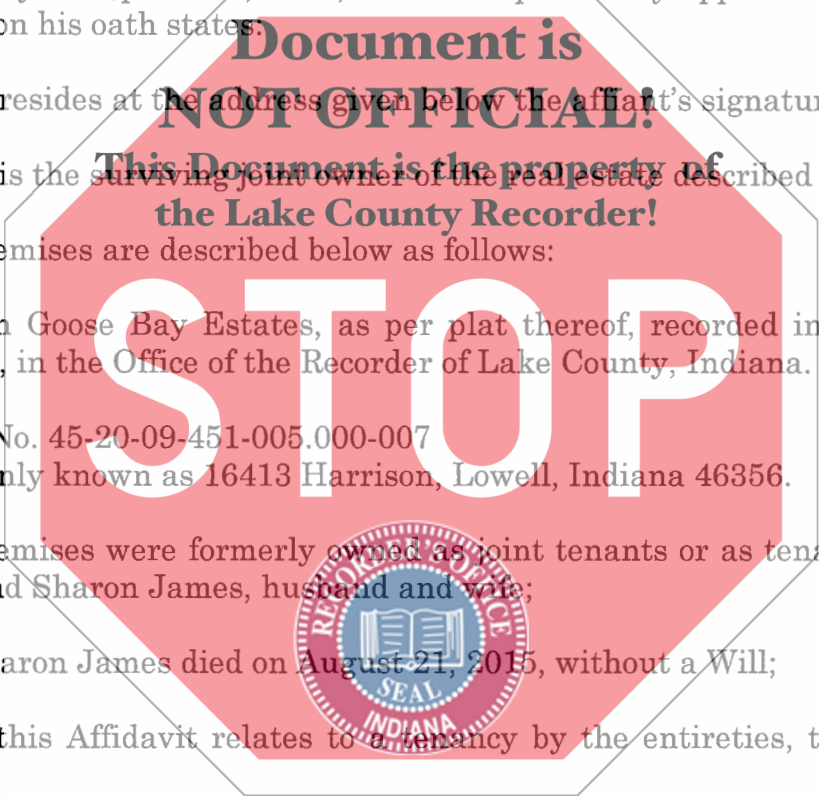
On this 14th day of September, 2015, before me personally appeared Michael James, who being duly sworn upon his oath states:

1. Affiant resides at the address given below the affiant's signature;
2. Affiant is the surviving joint owner of the real estate described below;
3. Said premises are described below as follows:

Lot 4 in Goose Bay Estates, as per plat thereof, recorded in Plat Book 71 page 39, in the Office of the Recorder of Lake County, Indiana.

Parcel No. 45-20-09-451-005.000-007
Commonly known as 16413 Harrison, Lowell, Indiana 46356.

4. Said premises were formerly owned as joint tenants or as tenants by the entireties by Michael James and Sharon James, husband and wife;
5. Said Sharon James died on August 21, 2015, without a Will;
6. Where this Affidavit relates to a tenancy by the entireties, that the parties were never divorced;



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SEP 15 2015

JOHN E. PETALAS
LAKE COUNTY AUDITOR

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7. Affiant's relationship to the deceased was spouse.

Affiant's Signature *Michael James*
Name Printed Michael James
Address 16413 Harrison Street
Lowell, Indiana 46356

Subscribed and sworn to before me, a Notary Public, this 14th day of September, 2015.



Benjamin T. Ballou
Benjamin T. Ballou, Notary Public
A Resident of Lake County

My Commission Expires:
November 21, 2015

BENJAMIN T. BALLOU
Notary Public, State of Indiana
Lake County
My Commission Expires
November 21, 2015

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.

Benjamin T. Ballou
Benjamin T. Ballou

This instrument prepared by: Benjamin T. Ballou
Attorney at Law
8700 Broadway
Merrillville, IN 46410



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Tracking No. 62949

Local No 002794

EDR No 00000465203

State No 039849

1. Decedent's Legal Name (First, Middle, Last) SHARON J JAMES				1a. Maiden Name (if female) HASTEN		2. Sex FEMALE	3. Time Of Death 19:19	4. Date Of Death (Month/Day/Year) 08/21/2015	
5. Social Security Number [REDACTED]		6a. Age - Yrs 47	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) 06/07/1968		8. Birthplace (City and State or Foreign Country) HAMMOND, IN
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input type="checkbox"/> Inpatient <input checked="" 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 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) ST ANTHONY MEDICAL CENTER OF CROWN POINT									
12. City Or Town, State, And Zip Code CROWN POINT, IN, 46307					13. County Of Death LAKE			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 MICHAEL T JAMES			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation NURSE		17. Kind Of Business/Industry HEALTH CARE	
18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town LOWELL		18d. Apt. No.	18e. Zip Code 46356	18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
18c. Street And Number 16413 HARRISON STREET		19. Decedent's Education ASSOCIATE DEGREE (AA, AS)		20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White		22. Father's Name (First, Middle, Last) RICHARD HASTEN	
22. Father's Name (First, Middle, Last) RICHARD HASTEN		23. Mother's Name (First, Middle, Last) DONNA HASTEN		23a. Mother's Maiden Last Name NA		24. Informant's Name MICHAEL T JAMES		24a. Relationship To Decedent HUSBAND	
24. Informant's Name MICHAEL T JAMES		24b. Mailing Address (Street And Number, City, State, Zip Code) 16413 HARRISON STREET, LOWELL, IN 46356		25. Place Of Disposition HEIGHTS CREMATORY		25c. Location - City, Town, And State CHICAGO HEIGHTS, IL		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):	
26. Was Coroner Contacted? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility LINCOLN RIDGE FUNERAL HOME, 7607 W. LINCOLN HIGHWAY, CROWN POINT, IN 46307				27a. Funeral Home License Number: FH88800070		27b. Signature Of Indiana Funeral Service Licensee ELI VUJKO, BY ELECTRONIC SIGNATURE	
27b. Signature Of Indiana Funeral Service Licensee ELI VUJKO, BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee): FD01008300		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 Of Death On Line A. Add Additional Lines If Necessary. IMMEDIATE CAUSE (FINAL DISEASE OR CONDITION RESULTING IN DEATH): A. MULTIPLE INJURIES		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 Of Death On Line A. Add Additional Lines If Necessary. 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		28. Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I.	
31. Did Tobacco Use Contribute To Death? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input 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 checked="" type="checkbox"/> Unknown If Pregnant Within The Past Year				33. Manner Of Death: <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input checked="" 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) 08/21/2015	
34. Date Of Injury (Month/Day/Year) 08/21/2015		35. Time Of Injury 19:19		36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area) INTERSECTEION		37. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		38. Location Of Injury - State INDIANA	
38. Location Of Injury - State INDIANA		38a. City Or Town LOWELL		38b. Street & Number 41 AND BELSHAW		38c. Apt. No.		38d. Zip Code 46356	
39. Describe How Injury Occurred MOTOR VEHICLE ACCIDENT						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Registered To Own (Specify)			
41. Signature, Of Person Certifying Cause Of Death: MERRILEE D. FREY, BY ELECTRONIC SIGNATURE						42. Certifier (Check Only One) <input type="checkbox"/> Certifying Physician <input checked="" type="checkbox"/> Coroner <input type="checkbox"/> Health Officer		43. Name, Address And Zip Code Of Person Certifying Cause Of Death: MERRILEE D. FREY, 2900 W. 93RD. AVE., CROWN POINT, IN 46307	
43. Name, Address And Zip Code Of Person Certifying Cause Of Death: MERRILEE D. FREY, 2900 W. 93RD. AVE., CROWN POINT, IN 46307						44. License Number		45. Date Certified 08/24/2015	
46. Additional Funeral Service Provider:						47. Akas:			
48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						49. For Registrar Only		Date Filed (Month/Day/Year): AUG 25 2015	
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)									



THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT
AUG 25 2015
Susan W Best, so

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