

SURVIVORSHIP AFFIDAVIT

STATE OF ILLINOIS )  
 ) SS:  
COUNTY OF COOK )

2017 004471

Saroya Cohen, being first duly sworn upon oath, deposes and says:

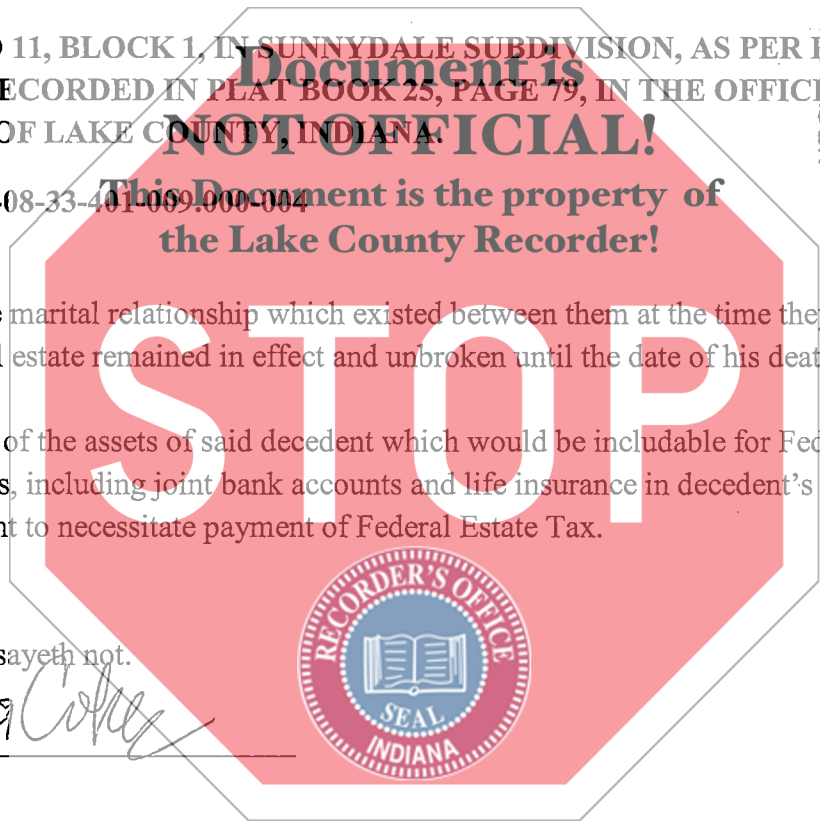
1. That Elijah Kelley died on April 6, 2014, in Indiana.
2. That Elijah Kelley and Saroya Cohen were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

**LOTS 10 AND 11, BLOCK 1, IN SUNNYDALE SUBDIVISION, AS PER THEREOF, RECORDED IN PLAT BOOK 25, PAGE 79, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.**

**KEY NO.: 45-08-33-401-009.000-004**  
**This Document is the property of the Lake County Recorder!**

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2017 JAN 18 AM 10:41  
MICHAEL J. BROWN  
RECORDER

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of his death.
4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance in decedent's life were not sufficient to necessitate payment of Federal Estate Tax.



Further affiant sayeth not.

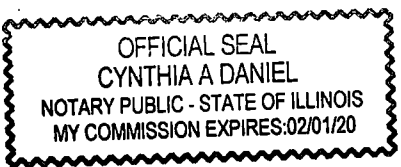
*Saroya Cohen*

Saroya Cohen



Subscribed and sworn to before me, a Notary Public, this 12<sup>th</sup> day of October, 2016.

*Cynthia A. Daniel*  
Notary



**FILED**

JAN 18 2017

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

814.00  
M-E  
NE

224A

CK# 1820501648

84208c inv.

CHICAGO TITLE INSURANCE COMPANY



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No 000156

EDR No 000000378728

State No

1. Decedent's Legal Name (First, Middle, Last) <b>ELIJAH KELLEY</b>		1a. Maiden Name (if female)		2. Sex <b>MALE</b>	3. Time Of Death <b>12:41 AM</b>	4. Date Of Death (Month/Day/Year) <b>04/06/2014</b>	
5. Social Security Number [REDACTED]	6a. Age - Yrs <b>66</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>07/26/1947</b>	
8. Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		9. If Death Occurred In A Hospital: <input checked="" 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>4924 VAN BUREN</b>							
12. City Or Town, State, And Zip Code <b>GARY, IN, 46408</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>SAROYA COHEN</b>		15a. (If WfW) Give Maiden Last Name <b>COHEN</b>		16. Decedent's Usual Occupation <b>GENERATOR STATION</b>		17. Kind Of Business/Industry <b>NIPSCO</b>	
18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>GARY</b>		18c. Street And Number <b>4924 VAN BUREN</b>	
18d. Apt. No.		18e. Zip Code <b>46408</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
19. Decedent's Education <b>SOME COLLEGE CREDIT, BUT NOT A DEGREE</b>		20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>Black or African American</b>			
22. Father's Name (First, Middle, Last) <b>ARIZONE KELLEY</b>		23. Mother's Name (First, Middle, Last) <b>LILLIAN KELLEY</b>		23a. Mother's Maiden Last Name <b>UNAVAILABLE</b>			
24. Informant's Name <b>SAROYA COHEN</b>		24a. Relationship To Decedent <b>WIFE</b>		24b. Mailing Address (Street and Number, City, State, Zip Code) <b>4924 VAN BUREN, GARY, IN 46408</b>			
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>HEIGHTS CREMATORY</b>		25c. Location - City, Town, And State <b>CHICAGO HEIGHTS, IL</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>CASTLE HILL FUNERAL HOME, 1219 SHEFFIELD AVE, DYER, IN 46311</b>				27a. Funeral Home License Number <b>FH10900001</b>	
27b. Signature Of Indiana Funeral Service Licensee <b>CHRISTOPHER CHELBANA, BY ELECTRONIC SIGNATURE</b>		27c. License Number Of Licensee <b>FD20700033</b>				Cause Of Death (See Instructions And Examples)	
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>ADENOCARCINOMA OF THE COLON WITH PROGRESSIVE LIVER METASTASIS</b>				Approximate Interval: Onset To Death <b>ONE YEAR</b>	
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. _____				Due to (Or As A Consequence Of)	
		C. _____				Due to (Or As A Consequence Of)	
		D. _____				Due to (Or As A Consequence Of)	
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 checked="" 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 checked="" 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 checked="" 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: <b>LYLE R MUNN, BY ELECTRONIC SIGNATURE</b>				42. Certifier (Check Only One): <input checked="" 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>LYLE R MUNN, 85 E. US HIGHWAY 6, MEDICAL PLAZA, STE 235, VALPARAISO, IN 46383</b>				44. License Number <b>01031582A</b>		45. Date Certified <b>04/08/2014</b>	
46. Additional Funeral Service Provider				47. Akas			
48. Signature Of Local Health Officer: <b>ROLAND H WALKER, VIA ELECTRONIC SIGNATURE</b>				49. For Registrar Only - Date Filed (Month/Day/Year) <b>APR 14 2014</b>			

