

2017 007148

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2017 FEB -1 AM 10:46

MICHAEL B. BROWN
RECORDER

3

Case # 1700199

SURVIVORSHIP AFFIDAVIT

Comes now William F. O'Brien, who being duly sworn upon his oath, deposes and says:

That, William F. O'Brien is the surviving spouse of Judith M. O'Brien, deceased who died domiciled in Lake County, Indiana, on 4/13/05.

That William F. O'Brien and Judith M. O'Brien acquired title to certain real estate as husband and wife, said real estate being described as follows:

LOT 5, MICHUDA'S ADDITION TO HAMMOND, AS SHOWN IN PLAT BOOK 22, PAGE 66, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Property Address: 6917 Alexander Ave., Hammond, IN 46323

State Tax ID: 45-07-09-328-007.000-023



Affiant states that William F. O'Brien and Judith M. O'Brien continued to live and cohabit together as husband and wife continuously from the date they took title to the above-described real estate, until the date of Judith M. O'Brien's death.

Affiant states that the total assets of said estate, including the proceeds of life insurance policies and real and personal property, were not sufficient to subject the estate to Federal Estate Tax and that Indiana Inheritance Tax, if any, has been paid.

This affidavit is made for the purpose of maintaining a clear record of title to the above-described real estate and to induce the appropriate county authority of Lake County, Indiana, to transfer the above-described real estate to William F. O'Brien.

Executed: 1/24/2017

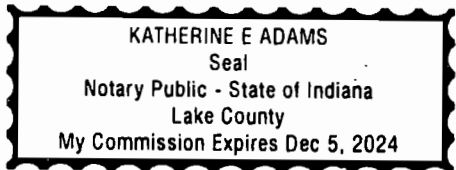
Signature William F. O'Brien
William F. O'Brien

STATE OF INDIANA

COUNTY OF Lake

Subscribed and sworn to before me, a Notary Public in and for said county and state on this 24th day of January, 2017.

Kath Adams
Notary Public _____
Resident of _____ County
My Commission expires: _____



Prepared by: William F. O'Brien

I affirm, under penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law William F. O'Brien

Return to: 6917 Alexander Ave.
Hammond, IN. 46323

FILED
JAN 31 2017
JOHN E. DETALAS
LAKE COUNTY AUDITOR

010638

15.
1820501672

CHICAGO TITLE INSURANCE COMPANY

EXHIBIT "A"

LOT 5, MICHUDA'S ADDITION TO HAMMOND, AS SHOWN IN PLAT BOOK 22, PAGE 66, IN
THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Property Address: 6917 Alexander Ave., Hammond, IN 46323 State Tax ID:
45-07-09-328-007.000-023



* 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 CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE COMPLETE COPY OF DEATH ON FILE WITH HAMILTON HEALTH DEPARTMENT.

Apr 14 2005
Date Issued
Hamilton Health Commission

Local No. 262

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

1. DECEASED—NAME (First, Middle, Last) JUDITH M. O'BRIEN		2. SEX Female		3a. TIME OF DEATH 05:28 A. M		3b. DATE OF DEATH (Month, Day, Yr) April 13, 2005			
4. *SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 46		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes			
6a. WAS DECEDENT A U.S. VETERAN No		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		6. DATE OF BIRTH (Mo, Day, Yr) November 12, 1958		7. BIRTHPLACE (City and State or Foreign Country) 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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				9b. FACILITY NAME (If not institution, give street and number) 7426 Arizona				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) William O'Brien	
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Owner/Operator				12b. KIND OF BUSINESS/INDUSTRY Beauty Shop				13a. RESIDENCE—STATE Indiana	
13b. COUNTY Lake				13c. CITY, TOWN, OR LOCATION Hammond				13d. STREET AND NUMBER 7426 Arizona	
13e. ZIP CODE 46323		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? USA		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) 12 College (1-4 or 5)				18. FATHER'S NAME (First, Middle, Last) Ernest Howard	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Deiotte				19. MAILING ADDRESS (Street, Rural Route Number, City or Town, State, Zip Code) 7426 Arizona Hammond, IN 46323				20c. Relationship Husband	
20a. INFORMANT'S NAME (Type/Print) William O'Brien		21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) April 15, 2005 Kelly-Carroll Cremation Service		21c. LOCATION—City or Town, State Gary, Indiana		22a. EMBALMERS NAME N/A	
22b. EMBALMERS LICENSE NO. N/A		22c. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		24a. SIGNATURE OF FUNERAL DIRECTOR <i>Leonard Scypura</i>		24b. LICENSE NUMBER (of Licensee) FD08800305		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home 7051 Kennedy Avenue Hammond, IN 46323 FH103000	
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. Vascular collapse DUE TO (OR AS A CONSEQUENCE OF) Due to arteriosclerotic heart and vascular disease		Approximate Interval Between Onset and Death Unknown		26. PART I (cont.) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d.		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) No		29a. CERTIFIER (Check only one) <input 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 checked="" 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. Chief Deputy 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. N/A		29d. DATE SIGNED (Month, Day, Year) April 14, 2005	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Jeffrey R. Wells, Chief Deputy, 2900 West 93rd Avenue, Crown Point, Indiana 46307		31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) April 14, 2005		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) April 13, 2005		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.							

