

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

2017 010842

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2017 FEB 21 PM 2:13

MICHAEL B. BROWN  
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Comes now Greg Farley, being of legal age and duly sworn upon his oath, who now states as follows:

1. That Greg Farley, is an adult and resides at 212 E. 6<sup>th</sup> Street, Apt. 1, Hobart, Lake County, Indiana 46342 and is the adult surviving son of Angel Farley.

2. That Angel Farley died on the 25<sup>th</sup> day of May, 2000 while domiciled in Hobart, Lake County, Indiana. A copy of her Death Certificate is attached hereto and marked as Exhibit "A".

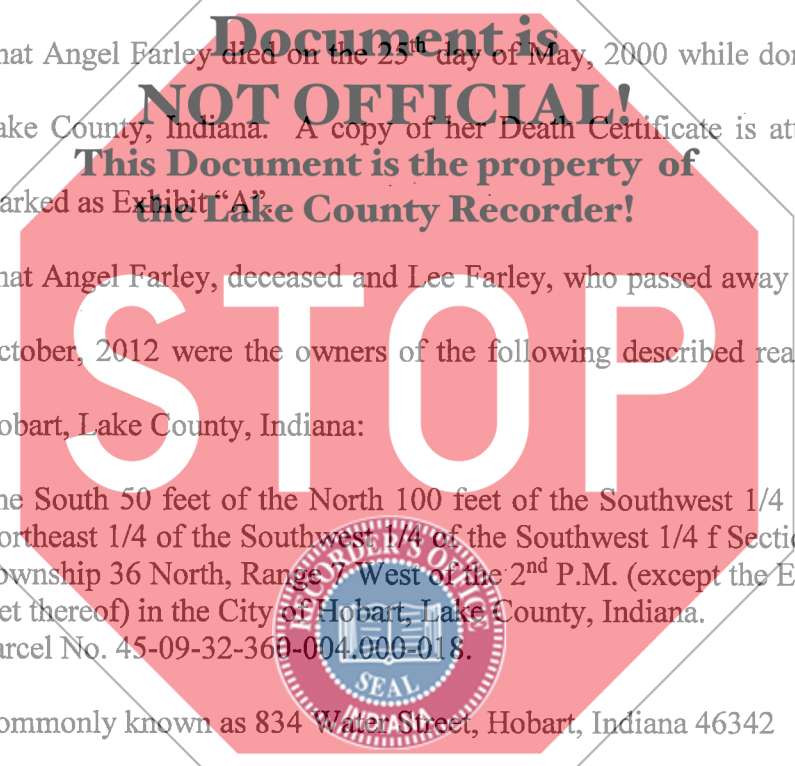
3. That Angel Farley, deceased and Lee Farley, who passed away on the 27<sup>th</sup> day of October, 2012 were the owners of the following described real estate located in Hobart, Lake County, Indiana:

The South 50 feet of the North 100 feet of the Southwest 1/4 of the Northeast 1/4 of the Southwest 1/4 of the Southwest 1/4 of Section 32, Township 36 North, Range 7 West of the 2<sup>nd</sup> P.M. (except the East 33 feet thereof) in the City of Hobart, Lake County, Indiana. Parcel No. 45-09-32-360-004.000-018.

Commonly known as 834 Water Street, Hobart, Indiana 46342

as tenants by the entireties and acquired title to said real estate on June 7, 1976 by Warranty Deed which instrument number is 356985 and was recorded on June 29, 1976.

4. That the decedent Angel Farley and her husband, Lee Farley lived together as husband and wife continuously until the time of the decedent, Angel Farley's death.



FILED

FEB 21 2017

15.  
6079  
FD

021315

JOHN E. PETALAS  
LAKE COUNTY AUDITOR



\* ATTENTION ESTATE: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Tracking No: 112646

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.....

Local No. 1A40-00

82030

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

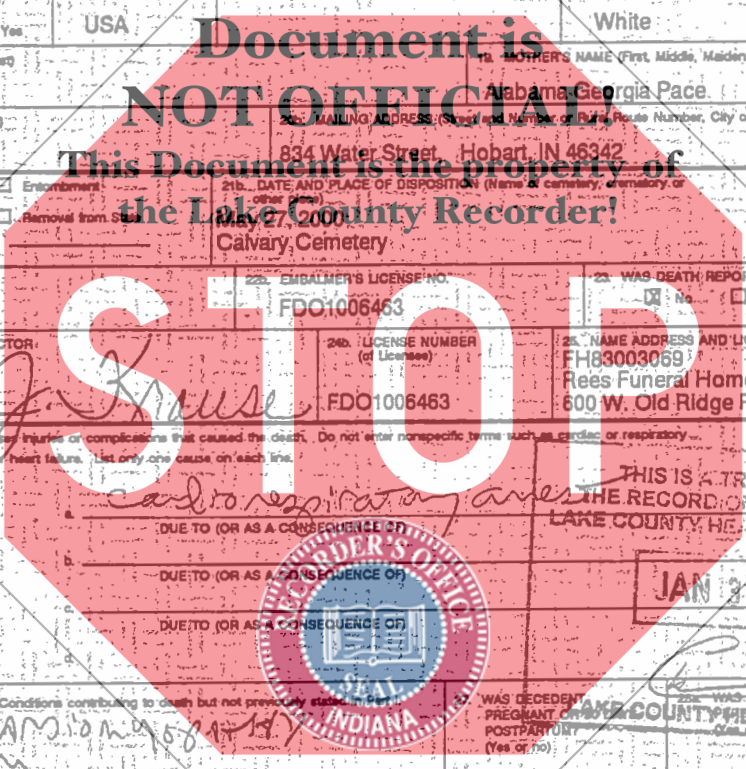
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED NAME (First, Middle, Last) <b>ANGEL B. FARLEY</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>4:53AM</b>	3b. DATE OF DEATH (Month, Day, Year) <b>May 25, 2000</b>
4. SOCIAL SECURITY NUMBER <b>[REDACTED]</b>	5a. AGE - Last Birthday (Years) <b>57</b>	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo Day Yr) <b>May 12, 1943</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Harlan County, Kentucky</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES <b>N/A</b>		8c. PLACE OF DEATH (Check only one: See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> OOA <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> Other (Specify) _____		
9a. FACILITY NAME: (If not institution, give street and number) <b>St. Mary Medical Center</b>		9b. CITY/TOWN OR LOCATION OF DEATH <b>Hobart</b>	9c. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Lee Farley</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Custodial Engineer</b>	12b. KIND OF BUSINESS/INDUSTRY <b>School</b>	
13a. RESIDENCE - STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY/TOWN OR LOCATION <b>Hobart</b>	13d. STREET AND NUMBER <b>834 Water Street</b>	
13a. ZIP CODE <b>46342</b>	13e. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY <b>USA</b>	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) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		18. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>		
19. FATHER'S NAME (First, Middle, Last) <b>John Wynn</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alabama Georgia Pace</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Lee Farley</b>		20b. MAILING ADDRESS (Street and Number or P.O. Box Number, City or Town, State, Zip Code) <b>834 Water Street, Hobart, IN 46342</b>		20c. Relationship <b>Husband</b>
21a. METHOD OF DISPOSITION <input checked="" 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) <b>Calvary Cemetery</b>		21c. LOCATION - City or Town State <b>Portage, Indiana</b>
22a. EMBALMER'S NAME <b>James J. Krause</b>		22b. EMBALMER'S LICENSE NO. <b>FDO1006463</b>		22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
23a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		23b. LICENSE NUMBER (of Licensee) <b>FDO1006463</b>		23c. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FHB3003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342</b>
24. PART I: Enter the disease, 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. <b>cardio respiratory arrest</b>				Approximate Interval Between Onset and Death <b>30 mins</b>
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>cardio respiratory arrest</b>				THIS IS A TRUE COPY OF THE RECORD ON FILE WITH LAKE COUNTY HEALTH DEPARTMENT <b>JAN 30 2017</b>
CONDITIONAL CAUSE (If any which gave rise to the immediate cause stating the underlying cause last) <b>Dilated cardiomyopathy</b>				
PART II: Other significant conditions - Conditions contributing to death but not previously stated on Part I <b>OBESITY</b>				
25a. 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.		25b. SIGNATURE AND TITLE OF CERTIFIER <i>Scott Kaufman</i>		25c. MEDICAL LICENSE NO. <b>02661632</b>
25d. DATE SIGNED (Month Day Year) <b>5/26/00</b>				<b>NOT VALID UNLESS</b>
26. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) <b>Scott Kaufman DO, 1500 South Lake Park Avenue, Hobart, IN 46342</b>				
27. HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>				28. DATE FILED (Month Day Year) <b>MAY 26 2000</b>
29. 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		30. DATE OF INJURY (Month Day Year)	31. TIME OF INJURY	32. INJURY AT WORK? (Yes or no)
33. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)		34. DESCRIBE HOW INJURY OCCURRED		
35. DATE PRONOUNCED DEAD (Month, Day, Year)		36. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes specify driver, passenger, pedestrian, etc.		



**EXHIBIT**  
"A"