STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2017 043211

2017 JUL 14 AM 9:43

MICHAEL B. BROWN
RECORDER

AFFIDAVIT OF SURVIVORSHIP

ON THIS 7th DAY OF July, 2017, personally appeared John C. Hicks, the affiant, who being duly sworn his upon oath, did say that:

1. Affiant resides at the address given below Affiant's signature;
2. Affiant is the personal representative of the Estate of Robert F. Bell;
3. Robert F. Bell was the owner in fee simple of the premises located at 6803 Rhode Island, Hammond, Indiana, and more particularly described as follows:

Lot 13 in block 9 in Cline Gardens Addition, in the City of Hammond, as per plat thereof, recorded in Plat Book 31, Page 71, in the Office of the Recorder of Lake County, Indiana.

Commonly known as: 6803 Rhode Island, Hammond, Indiana 46323
Tax ID No: 45-07-10-278-013.000-023

4. Said premises were owned by Lou Ann Bell and Robert F. Bell, as tenants by the entirety;
5. Said Lou Ann Bell died intestate on the 14th day of February, 2001;
6. To the best of affiant's knowledge, there is no Federal estate or State inheritance tax liability by reason of the death of said decedent;
7. Robert F. Bell's relationship to the deceased was her husband and the parties were married at the time of her death;
8. That this Affidavit is being filed to clarify the title to said real estate.

John C. Hicks, Affiant
Personal Representative of the
Estate of Robert F. Bell
613 E. Pine Place
Griffith, IN 46319

STATE OF INDIANA) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said county and state, personally appeared John C. Hicks, who acknowledged the execution of the foregoing, and who, having been duly sworn, stated that any representations therein contained are true, this 7th day of July, 2017.

My Commission expires: 11-5-2022

BRENDA SOHOVICH
Notary Public - Seal
State of Indiana
Porter County
My Commission Expires Nov 5, 2022

NOTARY PUBLIC

Resident of Porter County

This instrument prepared by:
BARBARA M. SHAVER, ESQ.
9013 Indianapolis Blvd.
Highland, IN 46322
219/838-9200

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.

Barbara M. Shaver

Return To: Barbara M. Shaver, 9013 Indianapolis Blvd., Highland, IN 46322
Send Tax Bills To: 6803 Rhode Island, Hammond, IN 46323

FILED

JUL 13 2017

JOHN E. PETALAS
LAKE COUNTY AUDITOR

031123

IN 00 2063

HOLD FOR GREATER INDIANA TITLE COMPANY
021408

Tracking No. 128209

ATTENTION ESTATE: The Social Security # is ing requested by this state agency in order to rsue its statutory responsibility. Disclosure is luntary and there will be no penalty for refusal.

ocal No. 363-01

#167953

YPE/PRINT IN ERMANENT LACK INK

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

ECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr)
LOUANN BELL	FEMALE	8:17 AM	FEBRUARY 14, 2001

4. *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr)	7 BIRTHPLACE (City and State or Foreign Country)
[redacted]	56			MAY 16, 1944	HAMMOND, INDIANA

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
NO	NONE	HOSPITAL ☐ Inpatient XX ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN, OR LOCATION OF DEATH	9d COUNTY OF DEATH
COMMUNITY HOSPITAL	MUNSTER	LAKE

10. MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	ROBERT F. BELL	KEY PUNCH OPERATOR	STEEL

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	6803 RHODE ISLAND AVENUE

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed)	
						Elementary/Secondary (0-12)	College (1-4 or 5 +)
46323	☐ No XX Yes	XX No ☐ Yes	USA	NO	WHITE	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
GEORGE F. METTEN	LUCILLE FLORENCE HILDEBRAND

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
ROBERT F. BELL	6803 RHODE ISLAND AVE, HAMMOND, IN 46323	HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
XX Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	FEBRUARY 16, 2001 CONCORDIA CEMETERY	HAMMOND, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
NA	NA	☐ No XX Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
Keith V. Anthony	01011911	ANTHONY & DZIADOWICZ F.H. #83002835 4404 CAMERON AVE, HAMMOND, IN 46327

CAUSE OF DEATH

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

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a ACUTE RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF)

b ATYPICAL PNEUMONIA CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF)

c

DUE TO (OR AS A CONSEQUENCE OF)

d

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

POST-CARCINOMA OF BREAST

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
NO	NO	NO

CERTIFIER

29a CERTIFIER (Check only one)

XX CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) as stated

☐ 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

☐ 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
Charles Dyke Egnatz M.D.	19054	FEB. 15, 2001

NOT VALID UNLESS RAISED SEAL AFFIXED

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)

CHAS DYKE EGNATZ, M.D. 1326 US ROUTE 30, SCHERERVILLE, INDIANA 46375

CERTIFIER

31 HEALTH OFFICER'S SIGNATURE Daniel L. Fortson, M.D.

32 DATE FILED (Month Day Year) February 16, 2001

THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

JUL 05 2017

LAKE COUNTY HEALTH OFFICER

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)	34h MOTOR VEHICLE ACCIDENT (Yes or no) If yes, specify driver, passenger, pedestrian, etc