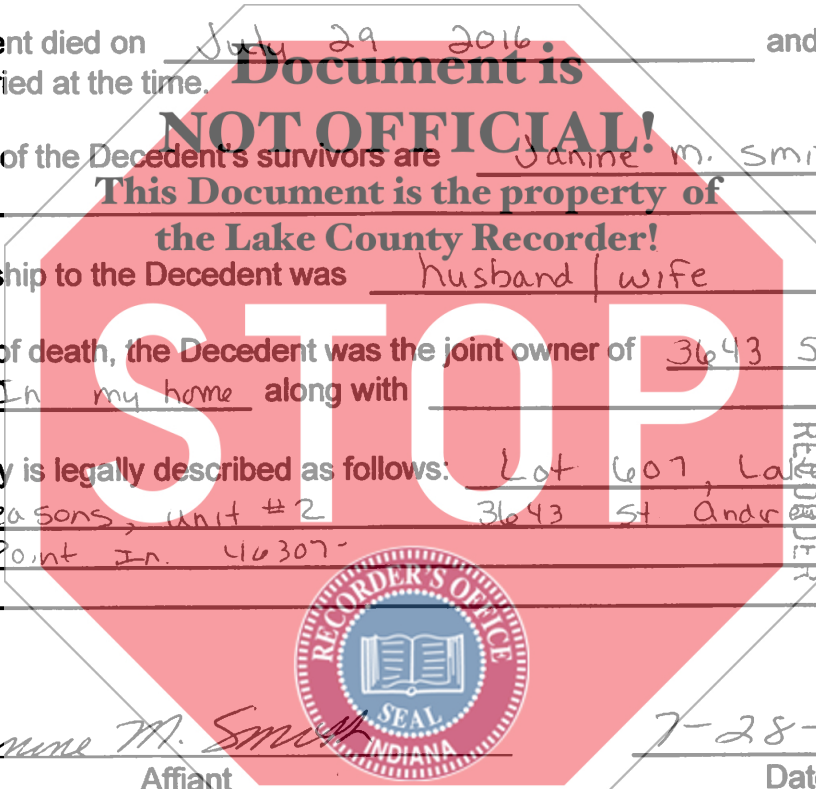


# AFFIDAVIT OF SURVIVORSHIP

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

I, Janine M. Smith, residing at 3643 St. Andrews Court  
Crown Point 46307  
in the county of Lake in the state of Indiana  
and being duly sworn, do hereby depose and attest that:

- The Decedent, Steven E. Smith, is named in the attached death certificate.
- The Decedent died on July 29 2016 and ~~(was)~~ was not legally married at the time.
- The names of the Decedent's survivors are Janine M. Smith
- My relationship to the Decedent was husband / wife
- At the time of death, the Decedent was the joint owner of 3643 St Andrews Ct. Crown Pt. In. my home along with \_\_\_\_\_
- The property is legally described as follows: Lot 607, Lakeside Four Seasons, Unit #2  
3643 St Andrews Court  
Crown Point In. 46307



2017 JUL 28 AM 10:28  
669911

STATE OF INDIANA  
LAKE COUNTY  
RECORDER'S OFFICE  
MICHAEL S. BROWN  
RECORDER

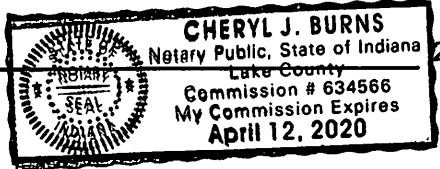
Janine M. Smith  
Affiant  
Janine M. Smith

7-28-2017  
Date

25. CAS# 12

Subscribed and sworn to before me this 28 day of July 20 17  
Cheryl Burns (Notary Public),  
County.

My commission expires \_\_\_\_\_ 20 \_\_\_\_\_



FILED  
JUL 28 2017

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

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025876

"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."  
PREPARED BY: [Signature]



INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tracking No. 95470

Local No 002458

EDR No 00000524429

State No 035935

1. Decedent's Legal Name (First, Middle, Last) <b>STEVEN E SMITH</b>				1a. Maiden Name (If female)		2. Sex <b>MALE</b>		3. Time Of Death <b>12:55 PM</b>		4. Date Of Death (Month/Day/Year) <b>07/29/2016</b>									
5. Social Security Number		6a. Age - Yrs <b>62</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>12/06/1953</b>		8. Birthplace (City and State or Foreign Country) <b>CHICAGO, IL</b>																	
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"/> 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) <b>ST MARY MEDICAL CENTER INC</b>																			
12. City Or Town, State, And Zip Code <b>HOBART, IN, 46342</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>JANINE M SMITH</b>				15a. (If Wife) Give Maiden Last Name <b>OLESTAD</b>				16. Decedent's Usual Occupation <b>SALES EXECUTIVE</b>		17. Kind Of Business/Industry <b>TOYS</b>									
18. Residence - State <b>INDIANA</b>			18a. County <b>LAKE</b>			18b. City Or Town <b>CROWN POINT</b>			18d. Apt. No.		18e. Zip Code <b>46307</b>								
18f. Inside City Limits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
18c. Street And Number <b>3643 ST. ANDREWS COURT</b>						18d. Apt. No.						18e. Zip Code <b>46307</b>							
19. Decedent's Education <b>MASTER'S DEGREE (MA, MS, MENG, MED, MSW, MBA)</b>						20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>			21. Decedent's Race <b>White</b>										
22. Father's Name (First, Middle, Last) <b>WILBERT SMITH</b>						23. Mother's Name (First, Middle, Last) <b>ROSEMARIE SMITH</b>						23a. Mother's Maiden Last Name <b>HAVNES</b>							
24. Informant's Name <b>JANINE SMITH</b>						24a. Relationship To Decedent <b>WIFE</b>						24b. Mailing Address (Street And Number, City, State, Zip Code) <b>3643 ST. ANDREWS COURT, CROWN POINT, IN 46307</b>							
25. Place Of Disposition																			
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>NORTHWEST INDIANA CREMATION SERVICES</b>				25c. Location - City, Town, And State <b>CROWN POINT, IN</b>											
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>BURNS FUNERAL HOME (CROWN POINT), 10101 BROADWAY, CROWN POINT, IN 46307</b>						27a. Funeral Home License Number <b>FH83002445</b>											
27b. Signature Of Indiana Funeral Service Licensee: <b>JAMES F. BURNS, BY ELECTRONIC SIGNATURE</b>						27c. License Number (Of Licensee): <b>FD01009461</b>													
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>LUNG CANCER</b> Due to (Or As A Consequence Of): <b>1 YR</b>																			
B. <b>BRAIN METASTASIS</b> Due to (Or As A Consequence Of): <b>MONTHS</b>																			
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 Finding 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 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 <b>AUG 04 2016</b>				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 <b>LAKE COUNTY HEALTH OFFICER</b>																			
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>BRETT ALAN BRECHNER, 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>BRETT ALAN BRECHNER, 9150 E. 109TH AVE. SUITE 2A, CROWN POINT, IN 46307</b>						44. License Number <b>02002495A</b>			45. Date Certified <b>08/02/2016</b>										
46. Additional Funeral Service Provider:																			
47. *Ages:																			
48. Signature of Local Health Officer: <b>CHANDANA VAVILALA, VIA ELECTRONIC SIGNATURE</b>						49. For Registrar Only - Date Filed (Month/Day/Year) <b>AUG 03 2016</b>													



THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT  
**AUG 04 2016**  
LAKE COUNTY HEALTH OFFICER

NOT VALID UNLESS

RAISED SEAL AFFIXED