

2017 048093

2017 AUG -2 PM 1:48

MICHAEL B. BROWN
RECORDER

Send Tax Bills to: 448 W. 400 N., Valparaiso, IN 46385

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

AFFIDAVIT OF SURVIVORSHIP

Comes now John F. Horn, Jr., and upon being duly sworn does attest and say:

1. That the affiant is the brother of Victor Horn, deceased.
2. That John F. Horn, Jr. and Victor Horn via the The Victor Horn Special Needs Trust, acquired the following property as Joint Tenants with Rights of Survivorship.

All of Lot 23 in Block 10 of Lloyd's Deep River Subdivision in the City of Lake Station, Lake County, Indiana as found in Plat Book 22, page 71 in the Office of the Lake County Recorder.

Parcel : 46082403902506020
Commonly known as: 1528 Park Avenue, Lake Station, Indiana 46405

3. That John F. Horn, Jr. and The Victor Horn Special Needs Trust held title as Joint Tenants with Rights of Survivorship until the death of Victor Horn on April 26, 2016.
4. That John F. Horn, Jr. became the fee simple owner of the property at the death of Victor Horn.

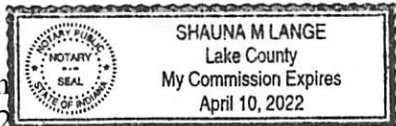
I affirm under the penalties for perjury that the foregoing statements are true.



STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Subscribed and sworn to before me this 27 day of July, 2017.

My Commission Expires: 4-10-22



Shauna M. Lange, Notary Public
Resident of Lake County

I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

Shauna M. Lange

This Instrument Prepared by: Patricia A. Rees, Attorney at Law, 5341 Central Ave., Portage, IN 46368
(219) 947-1692.

FILED

AUG 02 2017

JOHN E. PETALAS
LAKE COUNTY AUDITOR 026013

25.
acc. 14095
D



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Tracking No. 86632

Local No 001369

EDR No 00000508737

State No 019780

1. Decedent's Legal Name (First, Middle, Last) VICTOR W HORN				1a. Maiden Name (If female)		2. Sex MALE	3. Time Of Death 03:18 AM	4. Date Of Death (Month/Day/Year) 04/26/2016		
5. Social Security Number		6a. Age - Yrs 54	6b. Under 1 Year	6c. Under 1 Month	6d. Under 1 Day	6e. Under 1 Hour	7. Date of Birth (Month/Day/Year) 09/04/1961		8. Birthplace (City and State or Foreign Country) GARY, IN	
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"/> Inpatient <input checked="" 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 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) ST MARY MEDICAL CENTER INC							12. City Or Town, State, And Zip Code HOBART, IN, 46342		13. County Of Death LAKE	
15. Surviving Spouse's Name			15a. (If Wife) Give Maiden Last Name			16. Decedent's Usual Occupation ENVIRONMENTAL TECHNICIAN		17. Kind Of Business/Industry BUSINESS SERVICE		
18. Residence - State INDIANA			18a. County PORTER		18b. City Or Town VALPARAISO			18d. Apt. No.	18e. Zip Code 46385	
18c. Street And Number 448 WEST 400 NORTH			18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED			20. Decedent Of Hispanic Origin NOT HISPANIC		21. Decedent's Race White					
22. Father's Name (First, Middle, Last) JOHN F HORN			23. Mother's Name (First, Middle, Last) ANNIE HORN			23a. Mother's Maiden Last Name BOWDEN				
24. Informant's Name JOHN F HORN			24a. Relationship To Decedent BROTHER		24b. Mailing Address (Street And Number, City, State, Zip Code) 448 WEST 400 NORTH, VALPARAISO, IN 46385					
25a. Method Of Disposition <input checked="" type="checkbox"/> Burial <input 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) EDGAR CEMETERY			25c. Location - City, Town, And State PARIS, IL				
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility REES FUNERAL HOME OLSON CHAPEL, 5341 CENTRAL AVE, PORTAGE, IN 46368					27a. Funeral Home License Number: FB41200016			
27b. Signature Of Indiana Funeral Service Licensee: MELISA KATONA, BY ELECTRONIC SIGNATURE			27c. License Number (Of Licensee): FD20800088							
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. <u>CORONARY ARTERY DISEASE</u> Due to (Or As A Consequence Of): B. _____ Due to (Or As A Consequence Of): C. _____ Due to (Or As A Consequence Of): D. _____ Approximate Interval: Onset To Death 10 YEARS										
28. Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause (Give In Part I) HODGKINS DISEASE GIBLEED										
31. Did Tobacco Use Contribute To Death? <input 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 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. Were Autopsy Findings Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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) APR 27 2016			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: Susan W Best, M.D.				40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) NOT VALID UNLESS						
41. Signature, Of Person Certifying Cause Of Death: DON SQUIRES DUNEVANT, BY ELECTRONIC SIGNATURE						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: DON SQUIRES DUNEVANT, 814 LAPORTE AVE, VALPARAISO, IN 46385						44. License Number 01035863A		45. Date Certified 04/27/2016		
46. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE						47. For Registrar Only - Date Filed (Month/Day/Year): APR 27 2016				

