

Chicago Title Insurance Company

© TNW 1700532 SURVIVORSHIP AFFIDAVIT

On this 24th of August 2017 before me personally appeared (insert date) Melanie H. vanSickle

2017 058821

to me personally known, who being duly sworn on oath did say that:

- 1. Affiant resides at the address given below affiant's signature:
2. Affiant is Owner (state interest of affiant in the above premises as owner, "son of owner", etc.
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Erik L Schmidt and Melanie H van Sickle
4. Said Erik L Schmidt (fill in name of co-tenant who died) died on 5/19/17 leaving No will; (insert "a" or "no", if will left, attach a copy
5. The legal description of the premises in question is: See attached

Tax ID: 45-19-09-400-007.000-037

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? [ ] Yes [x] No

If yes, then estimated taxes due are \$

The taxes due are [ ] paid or [ ] unpaid..



STATE OF INDIANA LAKE COUNTY FILED FOR RECORD MICHAEL B. STORVICK 2017 AUG 30 AM 11:13

CHICAGO TITLE INSURANCE COMPANY

Chicago Title Insurance Company

FILED

AUG 29 2017

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25. 1820503669

JOHN E. PETALAS LAKE COUNTY AUDITOR

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NA

(If answer is "Yes" , identify the divorce proceedings:

NA ):

8. Affiant's relationship to the deceased was Joint Tenants



Signature: Melanie H. VanSickle  
Printed Name: Melanie H. VanSickle  
Address: 4611 FM 535  
Cedar Creek, TX  
78612

Subscribed and sworn to before me by the affiant

This 8/24/17  
(insert date)

[Signature]  
Notary Public

Printed Name Debra Lewis

My County of Residence is: Porter

In the State of Indiana

My Commission Expires 8/21/22

**DEBRA LEWIS**  
Notary Public, State of Indiana  
Porter County  
Commission # 657175  
My Commission Expires  
August 21, 2022

This instrument prepared by Melanie H. VanSickle

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 DL

**EXHIBIT "A"**  
Legal Description

For APN/Parcel ID(s): **45-19-09-400-007.000-037** 16468 Parrish Ave. Lowell, IN. 46356

LOT 2 IN EVERGREEN ACRES, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 87 PAGE 18 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.





INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Tracking No. 124390

Local No 001793

EDR No 00000578829

State No

1. Decedent's Legal Name (First, Middle, Last) <b>ERIK LOUIS SCHMIDT</b>		1a. Maiden Name (If female)		2. Sex <b>MALE</b>	3. Time Of Death <b>02:45 AM</b>	4. Date Of Death (Month/Day/Year) <b>05/19/2017</b>	
5. Social Security Number	6a. Age - Yr <b>73</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>06/12/1943</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"/> Inpatient: <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival		10a. If Death Occurred Somewhere Other Than A Hospital: <input checked="" 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 Inset on, Give Street and Number) <b>ST ANTHONY HOSPICE-CROWN POINT</b>				12. City Or Town, State, And Zip Code <b>CROWN POINT, IN, 46307</b>		13. County Of Death <b>LAKE</b>	
14. Marital Status At Time Of Death <input 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		15a. Last Name Before First Marriage		16. Decedent's Usual Occupation <b>TRUCK DRIVER</b>	
17. Kind Of Business/Industry <b>EXCAVATION</b>		18. Residence - State <b>INDIANA</b>		18a. County <b>LAKE</b>		18b. City Or Town <b>LOWELL</b>	
18c. Street And Number <b>16468 PARRISH AVENUE -</b>		18d. Apt. No.		18e. Zip Code <b>46356</b>		18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
19. Decedent's Education <b>HIGH SCHOOL GRADUATE OR GED COMPLETED</b>		20. Decedent Of Hispanic Origin <b>NOT HISPANIC</b>		21. Decedent's Race <b>White</b>			
22. Parent's Name (First, Middle, Last) <b>ARTHUR SCHMIDT</b>		23. Parent's Name (First, Middle, Last) <b>JACQUELINE SCHMIDT</b>		23a. Parent's Last Name Before First Marriage <b>GREEN</b>			
24. Informant's Name <b>JULIE SCHMIDT</b>		24a. Relationship To Decedent <b>DAUGHTER</b>		24b. Mailing Address (Street And Number, City, State, Zip Code) <b>1368 SNOW DRIVE, ELBERN, IN 46019</b>			
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, Crematorium, Other Facility) <b>BRONSWOOD CEMETERY</b>		25c. Place Of Disposition (City, Town, And State) <b>OAK BROOK, IL</b>			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility <b>ELMWOOD CHAPEL LTD, 11300 W 97TH LN, SAINT JOHN, IN 46373</b>				27a. Funeral Home License Number <b>FH19900052</b>	
27b. Signature Of Indiana Funeral Service Licensee: <b>AMES F BETKOWSKI, BY ELECTRONIC SIGNATURE</b>		27c. License Number Of Licensee: <b>PD05200077</b>		27d. THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT <b>MAY 22 2017</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>PROSTATE CANCER</b> B. _____ C. _____ D. _____ Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last							
Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I.							
1. 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"/> Pregnant At Time Of Death, But 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		Approximate Interval: Onset To Death	
4. Date Of Injury (Month/Day/Year)		35. Time Of Injury		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	
3. Location Of Injury - State		38a. City Or Town		38b. Street & Number		38c. Apt. No. 38d. Zip Code	
9. Describe How Injury Occurred						40. If Transportation Injury, Specify: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)	
1. Signature, Of Person Certifying Cause Of Death: <b>ATHRYN HENKLE MULLIGAN, BY ELECTRONIC SIGNATURE</b>				42. Certifier (Check Only One): <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer			
3. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>ATHRYN HENKLE MULLIGAN, 919 MAIN STREET, SUITE 102, DYER, IN 46311</b>				44. License Number <b>01052342A</b>		45. Date Certified <b>05/22/2017</b>	
5. Additional Funeral Service Provider: <b>RADY GILL FUNERAL HOME</b>				47. *AR#:			
3. Signature Of Local Health Officer: <b>HANDANA VAVILALA, VIA ELECTRONIC SIGNATURE</b>				46. For Registrar Only - Date Filed (Month/Day/Year): <b>MAY 22 2017</b>			

Document is NOT OFFICIAL!



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MAY 22 2017

RAISED SEAL AFFIXED

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.