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SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
COUNTY OF Lake)

SS:

Lois J Bullington [insert name of person making affidavit],

being first duly sworn upon oath deposes and says:

1. That Dennis R Bullington [insert name of deceased person] (the "Decedent") died on the September day of 9, 2013

at Hobart, Indiana 46342 [and insert location of death.]

2. That the Decedent and Lois J Bullington [insert name of Decedent's spouse] were duly and legally married at the time they acquired title as husband-and-wife to the following described real estate:

Legal Description: 1112 RAND STREET Hobart, Indiana 46344
45-09-29-203-014.000-018

SEE ATTACHED

- 3. That the marital relationship which existed between them at the time they acquire title to said real estate remained in effect and unbroken until the date of the decedent's death.
- 4. That all funeral expenses in connection with the death of the Decedent have been paid in full.
- 5. That all of the assets of the Decedent which would be includable for Federal State Tax purposes, including joint bank accounts and life insurance on the Decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Lois J Bullington
Signature of Affiant

Lois J Bullington
Type or Print Name

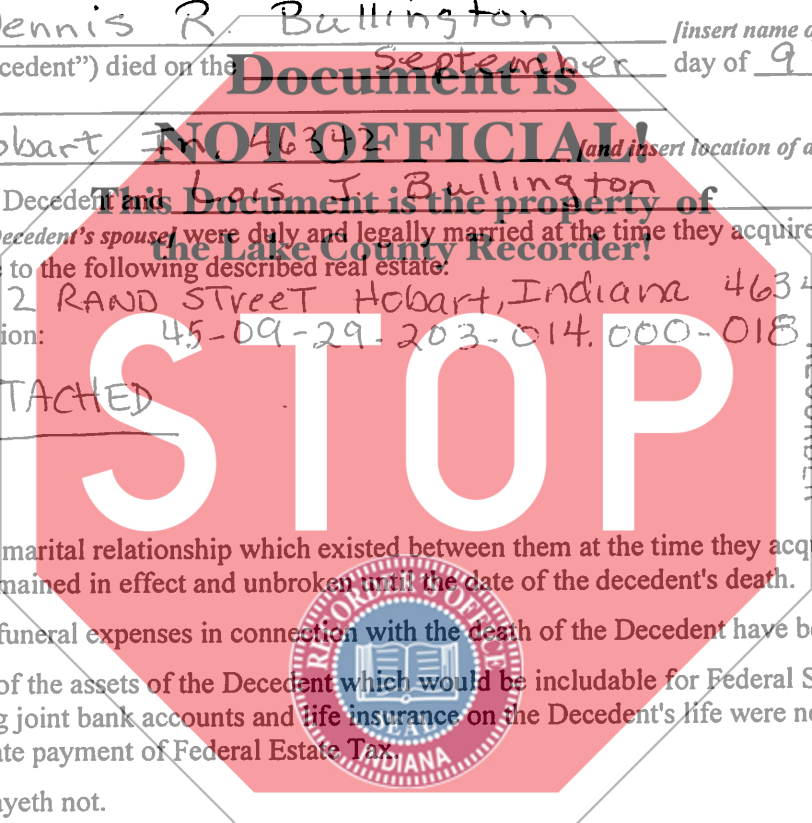
FILED

OCT 12 2017

JOHN E. PETALAS
LAKE COUNTY AUDITOR

027847

#25⁰⁰
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CAB



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MICHAEL E. BRONKHORST
RECORDER
2017 OCT 12 AM 10:45

2017
069451

STATE OF INDIANA)
COUNTY OF Lake)

SS: ACKNOWLEDGMENT

Before me, a Notary Public in and for said County and State, personally appeared Lois J. Bullington who acknowledged the execution of the foregoing instrument, and who, having been duly sworn, stated that any representations therein contained are true. Witness my hand and Notary Seal this 12th day of October, 20 17.

Resident of Lake County, Indiana Signature Rebecca M. Dykstra 10-12-17
My Commission Expires: 10-23-2020 Printed Rebecca M. Dykstra



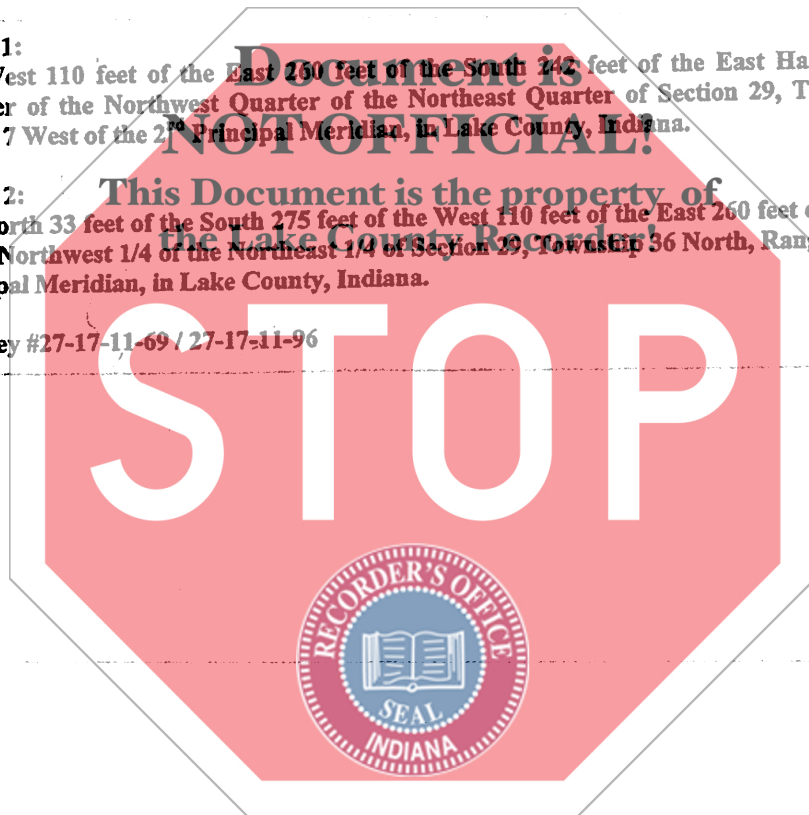
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"I AFFIRM, UNDER THE PENALTIES FOR PERJURY THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW."
PREPARED BY: [Signature]

Parcel 1:
The West 110 feet of the East 250 feet of the South 242 feet of the East Half of the Southeast Quarter of the Northwest Quarter of the Northeast Quarter of Section 29, Township 36 North, Range 7 West of the 2nd Principal Meridian, in Lake County, Indiana.

Parcel 2:
The North 33 feet of the South 275 feet of the West 110 feet of the East 260 feet of the Southeast 1/4 of the Northwest 1/4 of the Northeast 1/4 of Section 29, Township 36 North, Range 7 West of the 2nd Principal Meridian, in Lake County, Indiana.

Tax Key #27-17-11-69 / 27-17-11-96



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



Local No 003085

EDR No 00000342869

State No 042989

1. Decedent's Legal Name (First, Middle, Last) DENNIS RAY BULLINGTON		1a. Maiden Name (If female)		2. Sex MALE	3. Time Of Death 15:52	4. Date Of Death (Month/Day/Year) 09/09/2013	
5. Social Security Number*	6a. Age - Yrs 65	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) 08/26/1948	8. Birthplace (City and State or Foreign Country) BENTON, IL
9. Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input 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	
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 LOIS BULLINGTON		15a. (If Wife) Give Maiden Last Name BUTLER		16. Decedent's Usual Occupation MEAT MANAGER	
17. Kind Of Business/Industry GROCERY		18. Residence - State INDIANA		18a. County LAKE		18b. City Or Town HOBART	
18c. Street And Number 1112 EAST RAND STREET				18d. Apt. No.		18e. Zip Code 46342	
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) OSCAR RAY BULLINGTON		23. Mother's Name (First, Middle, Last) BETTY J BULLINGTON		23a. Mother's Maiden Last Name BAILEY			
24. Informant's Name LOIS BULLINGTON		24a. Relationship To Decedent WIFE		24b. Mailing Address (Street And Number, City, State, Zip Code) 1112 EAST RAND STREET, HOBART, IN 46342			
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) CALVARY CEMETERY		25c. Location - City, Town, And State PORTAGE, IN			
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27. Name And Complete Address Of Funeral Facility REES FUNERAL HOME, HOBART CHAPEL, 600 W OLD RIDGE RD, HOBART, IN 46342				27a. Funeral Home License Number: FH83003069	
27b. Signature Of Indiana Funeral Service Licensee JAMES J. KRAUSE, BY ELECTRONIC SIGNATURE		27c. License Number (Of Licensee): FD01006463		28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events. This is a TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. Immediate Cause (Final Disease Or Condition Resulting In Death) A. LUNG CANCER 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 N/A		29. Was An Autopsy Performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		29. Was An Autopsy Performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		30. Were Autopsy Findings 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		Approximate Interval: Onset To Death 14 MONTHS	
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)		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					
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: BALAGOPAL KERALAVARMA, 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: BALAGOPAL KERALAVARMA, 10110 DONALD POWERS DR STE 101B, MUNSTER, IN 46321	
44. License Number 01052677A		45. Date Certified 09/19/2013		46. Additional Funeral Service Provider:			
47. *Akas:		48. Signature of Local Health Officer: SUSAN W. BEST, VIA ELECTRONIC SIGNATURE		49. For Registrar Only - Date Filed (Month/Day/Year): SEP 20 2013			



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