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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2017 072271

2017 OCT 26 AM 9:12

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MICHAEL B. BROWN
RECORDER

SURVIVORSHIP AFFIDAVIT

Patricia L. Olson, being first duly sworn upon her oath deposes and says:

1. That Affiant and her husband, Robert W. Olson, acquired title to the following described real estate, commonly known as 8315 Baring Avenue, Munster, Lake County, Indiana, to-wit:

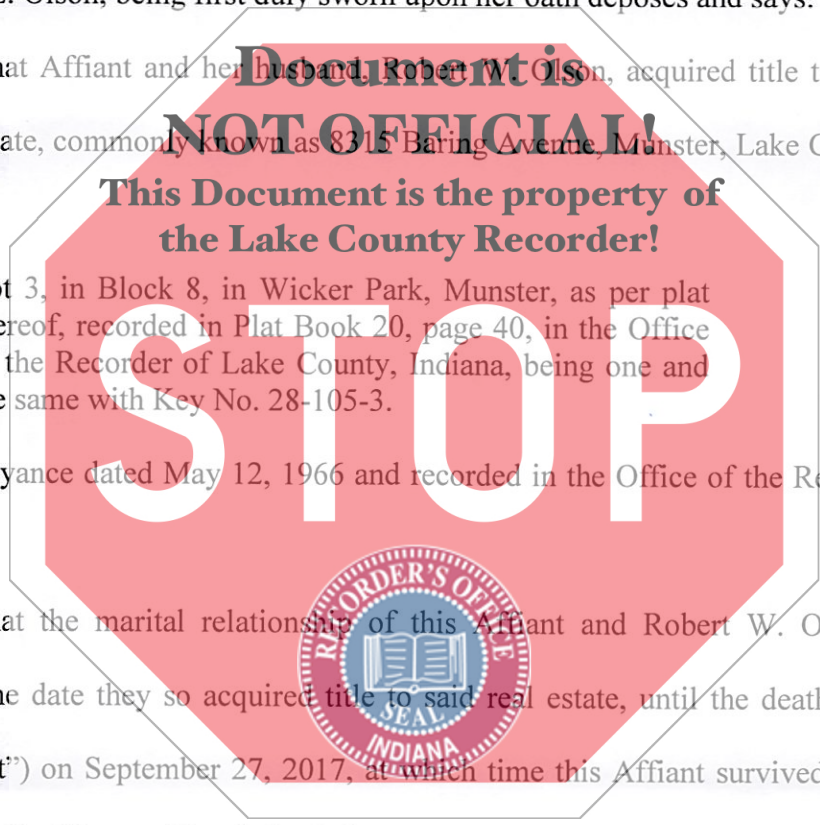
Lot 3, in Block 8, in Wicker Park, Munster, as per plat thereof, recorded in Plat Book 20, page 40, in the Office of the Recorder of Lake County, Indiana, being one and the same with Key No. 28-105-3.

by deed of conveyance dated May 12, 1966 and recorded in the Office of the Recorder of Lake County.

2. That the marital relationship of this Affiant and Robert W. Olson continued unbroken from the date they so acquired title to said real estate, until the death of Robert W. Olson ("Decedent") on September 27, 2017, at which time this Affiant survived as his widow. Certified copy of Certificate of Death for Robert W. Olson is attached hereto, made a part hereof and labeled *Exhibit "A."*

3. That no petition for the appointment of a personal representative is or was pending, or has been granted in any jurisdiction, and none is contemplated.

4. That Decedent's estate was not subject to Federal Estate Tax.



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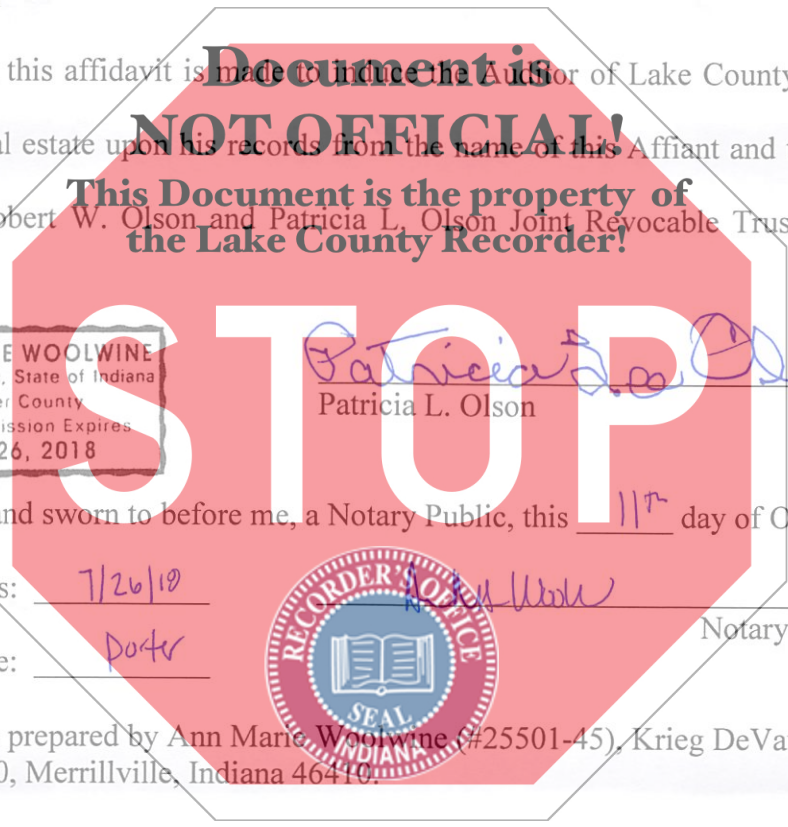
JOHN E. PETALAS
LAKE COUNTY AUDITOR

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5. Affiant makes this affidavit for the purpose of having the real estate located at 8315 Baring Avenue, Munster, Lake County, Indiana, transferred to the name of Patricia L. Olson as Trustee of the Robert W. Olson and Patricia L. Olson Joint Revocable Trust under date of August 30, 2013.

6. That this affidavit is made to induce the Auditor of Lake County to transfer the above described real estate upon his records from the name of this Affiant and the Decedent to the name of the Robert W. Olson and Patricia L. Olson Joint Revocable Trust under date of August 30, 2013.



Patricia L. Olson

Patricia L. Olson

Subscribed and sworn to before me, a Notary Public, this 11th day of October, 2017.

Commission Expires: 7/26/18 _____
Notary Public

County of Residence: Porter



This instrument was prepared by Ann Marie Woolwine (#25501-45), Krieg DeVault LLP, 8001 Broadway, Suite 400, Merrillville, Indiana 46410.

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: *Ann Marie Woolwine*



INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

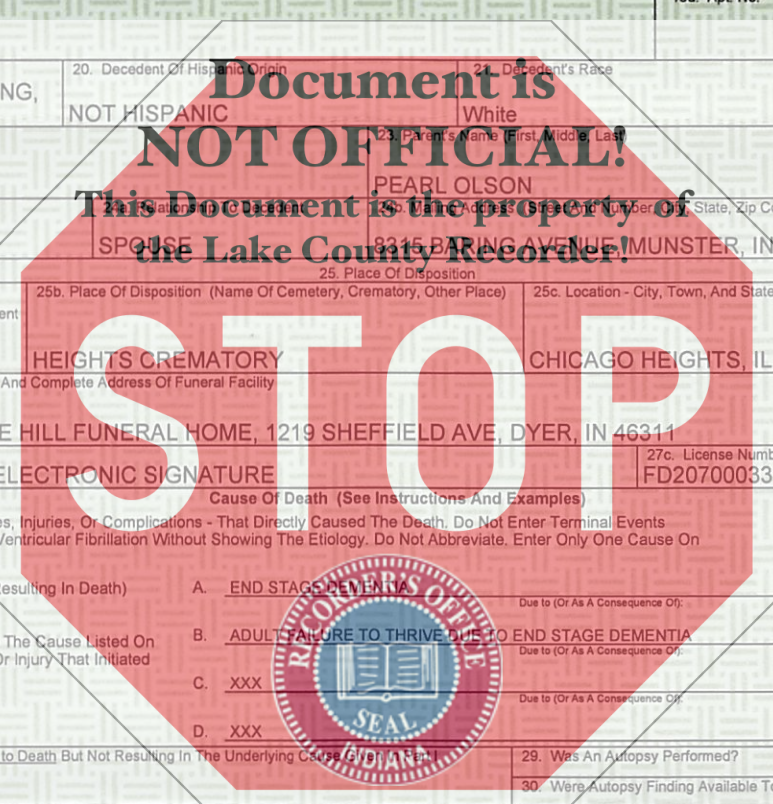
Tracking No. 136570

Local No 003320

EDR No 000000600804

State No 047409

| | | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|---|---|
| 1. Decedent's Legal Name (First, Middle, Last) ROBERT OLSON | | | | 1a. Maiden Name (If female) | | 2. Sex MALE | 3. Time Of Death 10:15 AM | 4. Date Of Death (Month/Day/Year) 09/27/2017 | | | |
| 5. Social Security Number | | 6a. Age - Yrs 80 | 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) 09/09/1937 | | 8. Birthplace (City and State or Foreign Country) FARGO, ND | | |
| 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 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 checked="" type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify) | | | | | |
| 11. Facility Name (If Not Institution, Give Street and Number) HARTSFIELD CARE CENTER | | | | | | 12. City Or Town, State, And Zip Code MUNSTER, IN, 46321 | | 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 PATRICIA LEE OLSON | | | 15a. Last Name Before First Marriage SULLIVAN | | 16. Decedent's Usual Occupation ENGINEER | | 17. Kind Of Business/Industry STEEL MILL | | | | |
| 18. Residence - State INDIANA | | 18a. County LAKE | | 18b. City Or Town MUNSTER | | 18d. Apt. No. | 18e. Zip Code 46321 | 18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 18c. Street And Number 8315 BARING AVENUE | | 19. Decedent's Education MASTER'S DEGREE (MA, MS, MENG, MED, MSW, MBA) | | 20. Decedent Of Hispanic Origin NOT HISPANIC | | 21. Decedent's Race White | | 22. Parent's Name (First, Middle, Last) WALTER P OLSON | | 23a. Parent's Last Name Before First Marriage RUDD | |
| 22. Parent's Name (First, Middle, Last) WALTER P OLSON | | 23. Parent's Name (First, Middle, Last) PEARL OLSON | | 23b. Parent's Address (Street And Number, City, State, Zip Code) SPOUSE 8315 BARING AVENUE, MUNSTER, IN 46321 | | 24. Informant's Name PATRICIA OLSON | | 25. Place Of Disposition HEIGHTS CREMATORY CHICAGO HEIGHTS, IL | | | |
| 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) | | 25c. Location - City, Town, And State | | 26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 27. Name And Complete Address Of Funeral Facility CASTLE HILL FUNERAL HOME, 1219 SHEFFIELD AVE, DYER, IN 46311 | | | 27a. Funeral Home License Number: FH10900001 |
| 27b. Signature Of Indiana Funeral Service Licensee: CHRISTOPHER CHELBANA, BY ELECTRONIC SIGNATURE | | 27c. License Number (Of Licensee): FD20700033 | | Cause Of Death (See Instructions And Examples) | | | | Approximate Interval: Onset To Death | | | |
| 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. | | | | A. END STAGE DEMENTIA Due to (Or As A Consequence Of): | | | | MONTHS | | | |
| 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 | | | | B. ADULT FAILURE TO THRIVE DUE TO END STAGE DEMENTIA Due to (Or As A Consequence Of): | | | | MONTHS | | | |
| | | | | C. XXX Due to (Or As A Consequence Of): | | | | XXX | | | |
| | | | | D. XXX Due to (Or As A Consequence Of): | | | | XXX | | | |
| Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause (If Any) | | | | | | 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 type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" 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 | | 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: ASHIR WAHAB, BY ELECTRONIC SIGNATURE | | | | | | 42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer | | 44. License Number 01067982A | | | 45. Date Certified 09/28/2017 |
| 43. Name, Address And Zip Code Of Person Certifying Cause Of Death: ASHIR WAHAB, 1573 N. CLINE AVENUE, GRIFFITH, IN 46319 | | | | | | 47. Akas: | | | | | |
| 46. Additional Funeral Service Provider: | | | | | | 48. Signature of Local Health Officer: CHANDANA VAVILALA, VIA ELECTRONIC SIGNATURE | | 49. For Registrar Only - Date Filed (Month/Day/Year): SEP 29 2017 | | | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | | | | | | | | | | |



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