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2020-083271

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
MICHAEL B BROWN
RECORDER

2020 Nov 17 3:28 PM

AFFIDAVIT OF SURVIVING JOINT TENANT

STATE OF INDIANA)
COUNTY OF) SS:

Sharon A.Crandall ("Affiant"), being first duly sworn upon oath,
deposes and says:

1. That Ann T. Crandall died on September 12, 2012 at Regency Hospital, Portage In A certified copy of the death certificate is attached hereto as Exhibit A.

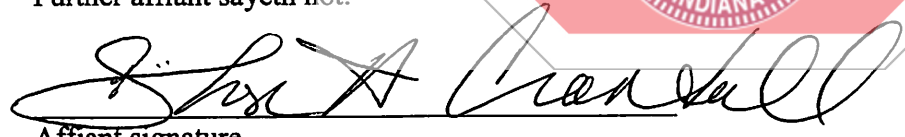
2. That Ann T. Crandall and Sharon A.Crandall acquired title as joint tenants with rights of survivorship to the following described real estate, recorded on May 24, 1991 as Plat Book 22, page 71 in the records of Lake County, Indiana:

Lot 1, Block 8, Lloyd's Deep River Subdivision
(Key No. 50-256-1 Unit 35)

Property address: 4029 E. Liverpool Road, Lake Station, IN 46405-1841
Parcel ID: 45-08-24-206-005.000-020

3. That Sharon A.Crandall makes these representations to set forth the present ownership of title to the above real estate pursuant to IC 32-17-2-1(c).

Further affiant sayeth not.



Affiant signature
Sharon A.Crandall

Print name
Date 10/1/20



FILED
NOV 17 2020
JOHN E. PETALAS
LAKE COUNTY AUDITOR

\$25.00

JKS

Deeds.com

cash

029

ACKNOWLEDGEMENT

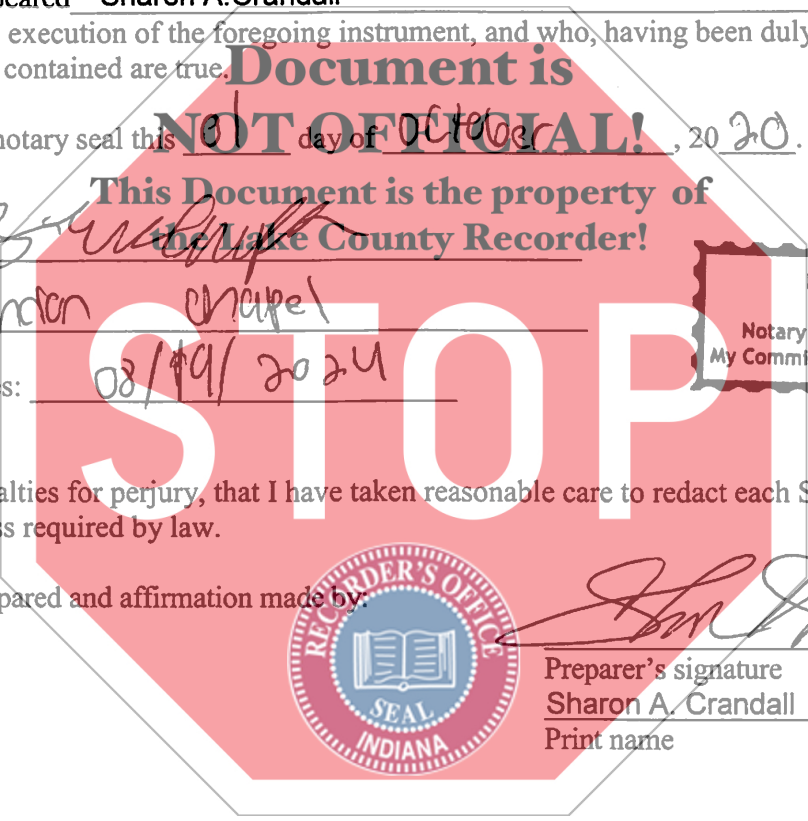
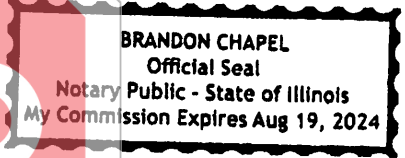
STATE OF INDIANA)
COUNTY OF _____) SS:

Before me, a notary public in and for said county and state, and a resident of _____ County, Indiana, personally appeared Sharon A. Crandall 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 01 day of October, 2020.

Notary signature: [Signature]
Print name: Brandon chapel

My commission expires: 08/19/2024



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.

This document was prepared and affirmation made by:

Sharon A. Crandall
4029 E. Liverpool Rd.
Lake Station, IN 46405



[Signature]
Preparer's signature
Sharon A. Crandall
Print name

After recording, please return instrument to:

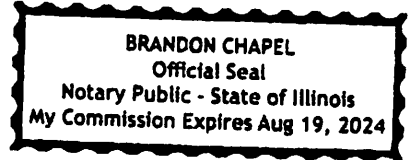
Sharon A. Crandall
4029 E. Liverpool Rd.
Lake Station, IN

CERTIFICATE OF PROOF

WITNESS to the signature (s) on the foregoing instrument to which this Proof is attached.

Witness Signature [Handwritten Signature]

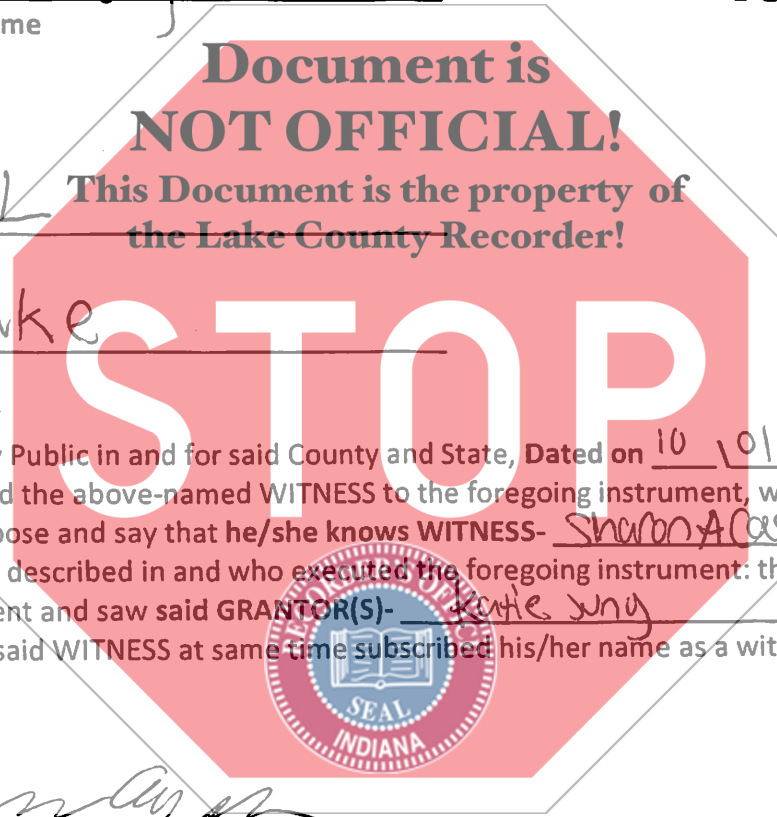
Witness Printed Name Katie Jung



PROOF:

STATE OF IL

COUNTY OF Lake



Before me a Notary Public in and for said County and State, Dated on 10/01/2020, personally appeared the above-named WITNESS to the foregoing instrument, who, being by me duly sworn, did depose and say that he/she knows WITNESS- Sharon A Casey, GRANTOR be the individual(s) described in and who executed the foregoing instrument: that said WITNESS was present and saw said GRANTOR(S)- Katie Jung execute the same: and the said WITNESS at same time subscribed his/her name as a witness thereto

Notary Public Signature [Handwritten Signature]

Notary Printed Name Brandon Chapel

Notary Name exactly as Commission
Notary Public- State of
Seal
My Commission Expires: aug 19, 2024
Commission No: _____



**INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH**

copy

Local No **001022**

EDR No **000000282829**

State No **044322**

| | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Legal Name (First, Middle, Last) ANN T CRANDALL | | | | 1a. Maiden Name (if female) REPISCAK | | 2. Sex FEMALE | 3. Time Of Death 07:14 AM | 4. Date Of Death (Month/Day/Year) 09/29/2012 | | |
| 5. Social Security Number 342-16-0032 | 6a. Age - Yrs 89 | 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) 06/08/1923 | | 8. Birthplace (City and State or Foreign Country) CHICAGO, IL | | |
| 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 checked="" 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 type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify) | | | | | |
| 11. Facility Name (If Not Institution, Give Street and Number) REGENCY HOSPITAL | | | | | | | | | | |
| 12. City Or Town, State, And Zip Code PORTAGE, IN, 46368 | | | | | 13. County Of Death PORTER | | 14. Marital Status At Time Of Death <input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown | | | |
| 15. Surviving Spouse's Name | | | | 15a. (If Wife) Give Maiden Last Name | | 18. Decedent's Usual Occupation CUSTOMER SERVICE | | 17. Kind Of Business/Industry RESTAURANT | | |
| 18. Residence - State INDIANA | | | 18a. County LAKE | | 18b. City Or Town LAKE STATION | | 18d. Apt. No. | 18e. Zip Code 46405 | 18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 18c. Street And Number 4029 LIVERPOOL ROAD | | | 20. Decedent Of Hispanic Origin NOT HISPANIC | | 21. Decedent's Race White | | | | | |
| 19. Decedent's Education HIGH SCHOOL GRADUATE OR GED COMPLETED | | | 22. Father's Name (First, Middle, Last) JOHN REPISCAK | | 23. Mother's Name (First, Middle, Last) MARY REPISCAK | | | 23a. Mother's Maiden Last Name MELON | | |
| 24. Informant's Name WAYNE CRANDALL | | | 24a. Relationship To Decedent SON | | 24b. Mailing Address (Street And Number, City, State, Zip Code) 3161 HICKORY STREET, PORTAGE, IN 46368 | | | | | |
| 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) NW INDIANA CREMATION SERVICE | | | 25c. Location - City, Town, And State CROWN POINT, IN | | | | | |
| 26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 27. Name And Complete Address Of Funeral Facility BURNS FUNERAL HOME, 701 E. 7TH ST., HOBART, IN 46342 | | | | | 27a. Funeral Home License Number: FH83002380 | | | |
| 27b. Signature Of Indiana Funeral Service Licensee: JAMES F. BURNS, BY ELECTRONIC SIGNATURE | | | | | | 27c. License Number (Of Licensee): FD0100946T | | | | |
| 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. MULTI ORGAN FAILURE 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. C. D. | | | | | | | | Approximate Interval: Onset To Death LESS THAN 6 MONTHS | | |
| Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I. MULTI ORGAN FAILURE | | | | | | | | 29. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 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 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: JOSE LUIS AGUSTI, 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: JOSE LUIS AGUSTI, 60 VALPARAISO STREET, VALPARAISO, IN 46383 | | | | | | 44. License Number 01061624A | | 45. Date Certified 10/04/2012 | | |
| 46. Additional Funeral Service Provider: | | | | | | 47. *Akas: | | | | |
| 48. Signature of Local Health Officer: MARIA L STAMP, VIA ELECTRONIC SIGNATURE | | | | | | 49. For Registrar Only - Date Filed (Month/Day/Year): OCT 10 2012 | | | | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | | | | | | | | | |