

# NOT AN OFFICIAL DOCUMENT

## SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA )  
COUNTY OF PORTER )

SS:  
)

I, Ellen Emerson, also known as Ellen L. Emerson, wife of the deceased, James Emerson, also known as James L. Emerson, deposes and says:

1. I makes this Affidavit of my own knowledge.
2. That James Emerson, also known as James L. Emerson, passed away on November 6, 2023, in Crown Point, Indiana, a resident of Lake County, Indiana. A copy of his death certificate is attached hereto as Exhibit "A".
3. That I was married to the deceased, James Emerson, also known as James L. Emerson, on the date of his death and am qualified to make this affidavit as I am the closest person to the deceased on the date of his death.
4. That James Emerson, also known as James L. Emerson, did have a Will.
5. That no administration was had on his estate, nor was any necessary and no estate or inheritance taxes were due upon his death.
6. That James Emerson, also known as James L. Emerson, and I, owned real property as husband and wife, in Lake County, Indiana, at the time of his death, specifically 735 Maple Lane, Crown Point, IN 46307. Legal Description: LOT NUMBERED NINE (9) IN GREENMEADOW MANOR UNIT NO. 3 IN THE CITY OF CROWN POINT, AS PER PLAT THEREOF RECORDED IN PLAT BOOK 35, PAGE 10 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY. Property Number: 45-16-17-226-017-000-042
7. That title to said real estate remained in effect and unbroken on the date of his death.
8. That all funeral expenses in connection with the death of the decedent have been paid.

I affirm that I have taken reasonable care to redact social security numbers herein. Further affiant sayeth not.

*Ellen L. Emerson*

Ellen L. Emerson, also known as Ellen L. Emerson, Affiant

### ACKNOWLEDGEMENT

STATE OF INDIANA )  
COUNTY OF PORTER )

SS:  
)

Before me, a Notary Public, personally appeared the above-named, who acknowledged the execution of the foregoing instrument, and who, having been duly sworn, stated that any representations therein contained are true and accurate. Witness my hand and seal this 1<sup>st</sup> day of February, 2024.

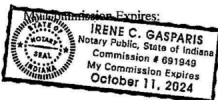
*Irene Gasparis*  
Notary Public

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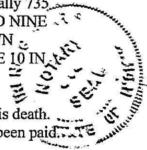
FEB 01 2024

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR



Prepared by: Atty Irene Gasparis, 305 S. Main, Crown Point, IN 46307  
219-661-6000

GINA PIMENTEL  
RECORDER  
STATE OF INDIANA  
LAKE COUNTY  
RECORDED AS PRESENTED  
2024-005079  
11:23 AM 2024 Feb 1





# NOT AN OFFICIAL DOCUMENT

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Track ID: 382841

Local No 003924

EDR No 000011635061

State No 2023-058094

|   |  |  |  |   |   |   |   |   |  |   |               |
|---|--|--|--|---|---|---|---|---|--|---|---------------|
| 1. Decedent's Legal Name (First, Middle, Last)<br><b>James L. Emerson</b>   |  |  |  | 1a. Maiden Name (If Female)   |   | 2. Gender<br><b>Male</b>  | 3. Time Of Death<br><b>03:05 AM</b>   | 4. Date Of Death (Month/Day/Year)<br><b>11/06/2023</b>  |  |   |               |
| 5. Social Security Number<br><b>[REDACTED]</b>  |  | 6a. Age - Yrs<br><b>78</b>   | 6b. Under 1 Year<br>Months   | 6c. Under 1 Month<br>Days   | 6d. Under 1 Day<br>Hours  | 6e. Under 1 Hour<br>Minutes   | 7. Date of Birth (Month/Day/Year)<br><b>04/27/1945</b>  |   | 8. Birthplace (City and State or Foreign Country)<br><b>Gary, Indiana</b>                  |   |               |
| 9. Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 10. If Death Occurred in a Hospital:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department/Outpatient <input type="checkbox"/> Dead on Arrival |  | 11a. If Death Occurred Somewhere Other Than a Hospital:<br><input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility |   | 11b. If Death Occurred Somewhere Other Than a Hospital:<br><input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-Term Care Facility |   | 11c. Other (Specify)  |  |   |               |
| 11. Facility Name (If Not Institution, Give Street and Number)<br><b>Franciscan Health Crown Point</b>  |  |  |  |   |   |   |   |   |  |   |               |
| 12. City Or Town, State, And Zip Code<br><b>Crown Point, Indiana 46307</b>  |  |  |  |   | 13. County Of Death<br><b>Lake</b>  |   |   | 14. Marital Status At Time Of Death<br><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<br><b>Ellen L. Emerson</b>  |  |  |  |   | 15a. Last Name Before First Marriage<br><b>Weeks</b>  |   |   | 16. Decedent's Usual Occupation<br><b>Vice President</b>  |  | 17. Kind Of Business Industry<br><b>Banking</b> |               |
| 18. Residence - State<br><b>IN</b>  |  |  | 18a. County<br><b>Lake</b>   |   | 18b. City Or Town<br><b>Crown Point</b>   |   |   |   |  |   |               |
| 19c. Street And Number<br><b>735 Maple Lane</b>   |  |  | 18d. Apt. No.  |   | 18e. Zip Code<br><b>46307</b>   |   | 18f. Inside City Limits?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |               |
| 19. Decedent's Education<br><b>Some college, but no degree</b>  |  |  | 20. Decedent Of Hispanic Origin<br><b>Not Spanish/Hispanic/Latino</b>  |   |   | 21. Decedent's Race<br><b>White</b>   |   |   |  |   |               |
| 22. Parent's Name (First, Middle, Last)<br><b>William Emerson</b>   |  |  |  |   | 23. Parent's Name (First, Middle, Last)<br><b>Virginia Emerson</b>  |   |   | 23a. Parent's Last Name Before First Marriage<br><b>Johnson</b>   |  |   |               |
| 24. Informant's Name<br><b>Ellen L. Emerson</b>   |  |  | 24a. Relationship To Decedent<br><b>Wife</b>   |   |   | 24b. Mailing Address (Street And Number, City, State, Zip Code)<br><b>735 Maple Lane, Crown Point, IN, 46307</b>  |   |   |  |   |               |
| 25. Place Of Disposition  |  |  |  |   |   |   |   |   |  |   |               |
| 25a. Method Of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment<br><input type="checkbox"/> Removal From State<br><input type="checkbox"/> Other (Specify):  |  |  | 25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)<br><b>Northwest Indiana Cremation Services</b>                      |   |   | 25c. Location - City, Town, And State<br><b>Crown Point, IN</b>   |   |   |  |   |               |
| 26. Was Coroner Contacted?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 27. Name And Complete Address Of Funeral Facility<br><b>Burns Funeral Home (Crown Point) 10101 Broadway, Crown Point, Indiana, 46307</b> |   |   | 27a. Funeral Home License Number<br><b>FH83002445</b>   |   |   |  |   |               |
| 27b. Signature Of Indiana Funeral Service Licensee<br><b>James F. Evans</b>   |  |  |  |   | Electronically Signed   |   |   | 27c. License Number Of Licensee:<br><b>FD01009461</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 4 Lines. Add Additional Lines If Necessary.                                  |  |  |  |   |   |   |   |   |  |   |               |
| Immediate Cause (Final Disease Or Condition Resulting In Death)   |  |  |  |   |   |   |   |   |  |   |               |
| A. <b>Saddle Pulmonary Embolus</b>  |  |  | immediate  |   |   |   |   |   |  |   |               |
| 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. _____  |  |  | _____  |   |   |   |   |   |  |   |               |
| Part II. Enter Other Significant Conditions Contributing To Death, But Not Resulting In The Underlying Cause Given in Part I  |  |  |  |   |   |   |   |   |  |   |               |
| 29. Was An Autopsy Performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   | 30. Were Autopsy Findings Available To Complete The Cause Of Death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                          |   |   |   |  |   |               |
| 31. Did Tobacco Use Contribute To Death?<br><input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  |  |  |   |   |   |   |   |  |   |               |
| 32. If Female:<br><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"/> Pregnant At Time Of Death, But Pregnant 43 Days To 1 Year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year |  |  |  |   |   |   |   |   |  |   |               |
| 33. Manner Of Death<br><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   |  |  | 37. Injury At Work?<br><input type="checkbox"/> Yes <input checked="" 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, Worked Area)   |   |   | 37. Injury At Work?<br><input type="checkbox"/> Yes <input checked="" 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:<br><input type="checkbox"/> Driver/Operator <b>NOT VALID UNLESS</b>  |  |  |  |   |   |   |   |   |  |   |               |
| 41. Signature - Of Person Certifying Cause Of Death:<br><b>Mary Lynn Raymond</b>  |  |  |  |   | 42. Certifier (Check Only One)<br><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:<br><b>Mary Lynn Raymond 10860 Maple Lane, Saint John, IN 46373</b>  |  |  |  |   | 44. License Number<br><b>01077733A</b>  |   | 45. Date Certified<br><b>11/09/2023</b>   |   |  |   |               |
| 46. Additional Funeral Services Provider:   |  |  |  |   |   |   |   |   |  |   |               |
| 48. Signature of Local Health Officer:<br><b>Chandana Vavilala</b>  |  |  |  |   | Electronically Signed   |   |   | 49. For Registrar Only - Date Filed (Month/Day/Year)<br><b>11/13/2023</b>   |  |   |               |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)<br>LAKE COUNTY HEALTH OFFICER   |  |  |  |   |   |   |   |   |  |   |               |