

2025-564987
02/13/2025 03:06 PM
TOTAL FEE: \$5.00
BY: JAS
PG #: 3
RECORDED AS PRESENTED

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
GINA PIMENTEL
RECORDER

FILED

Feb 13 2024 BDD
PEGGY HOLINGA-KATONA
LAKE COUNTY AUDITOR

Survivorship Affidavit

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

Concetta Owens, being duly sworn, upon her oath deposes and says:

Affiant and Robert C. Owens acquired title to the following described real estate located in Lake County, Indiana, to wit:

The West 350.0 feet of the South 373.37 feet of the East 1/2, Southeast 1/4, Southwest 1/4 Section 2, Township 32 North, Range 9 West of the 2nd P.M., except the west 20 feet of the South 250.0 feet thereof, in Lake County, Indiana.

Robert C. Owens and Concetta Owens, husband and wife, by Warranty Deed dated April 30, 1996, recorded May 2, 1996, in Instrument No. 1996-28672, in the Office of the Recorder of Lake County, Indiana.

The Affiant and the deceased remained in title as husband and wife, from the date they acquired title to said real estate, until the death of the decedent on the 24th day of July, 2018, at which time this affiant acquired all the right, title and interest in and to the subject property, pursuant to the terms in the aforementioned Deed. This affidavit is made to induce the Auditor of Lake County to transfer the above-described real estate upon its records from the name of the decedent to the names of Britney J. Markovich and John A. Markovich, wife and husband, whom this affiant sold the property to on September 24, 2021, by Warranty Deed recorded October 5, 2021, in Instrument No. 2021-531124, in the Office aforesaid.

NOT AN OFFICIAL DOCUMENT

Concetta Owens

Concetta Owens

On this day before me, the undersigned Notary Public, personally appeared Concetta Owens, to me known to be the individual described in and who executed the Affidavit of Survivorship, and acknowledged that ^{she JLG} he signed the Affidavit of Survivorship as ^{her JLG} his free and voluntary act and deed for uses and purposes therein mentioned.

Given under my hand and official seal this 13 day of February, 2024.

Jamie L. Goodwin

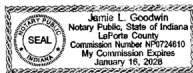
Notary Public

Jamie L. Goodwin

Printed Name

Resident of LaPorte County

My Commission Expires: 1-16-2028



I affirm, under the penalties of perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law. Shawn R. Freibert

This instrument was prepared by
Shawn R. Freibert, Attorney-at-Law – Acuity Title
800 Lily Creek Road, Suite 102
Louisville, KY 40243
502-238-7500

File Number: 37605



NOT AN OFFICIAL DOCUMENT

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

Form No. 10-2018

Local No 902466

EDR No 00000556398

State No 036507

| | | | | | | | |
|---|---------------|--|-------------------|--|------------------|--|---|
| Decedent's Legal Name (Print, Middle, Last) | | 3a. Maiden Name (if any) | | 2. Sex | 3. Time of Death | 4. Date of Death: (Month/Day/Year) | |
| ROBERT C OWENS | | | | MALE | 02:00 AM | 07/24/2018 | |
| 5. Social Security Number | 6a. Age - Yrs | 6b. Under 1 Year | 6c. Under 1 Month | 6d. Under 1 Day | 6e. Under 1 Hour | 7. Date of Birth (Month/Day/Year) | 8. Birthplace (City and State or Foreign Country) |
| | 65 | Months | Days | Hours | Minutes | 07/21/1953 | PRINCETON, IN |
| 9. Ever in U.S. Armed Forces? | | 10. If Death Occurred in a Hospital | | 11a. If Death Occurred Somewhere Other Than a Hospital | | 11b. Decedent's Home | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival | | <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. Family Name (If Not Institution, Give Street and Number) | | 13. County Of Death | | 14. Marital Status At Time Of Death | |
| ST MARGARET MERCY HEALTHCARE CENTERS-DYER | | LAKE | | <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 | |
| 12. City Or Town, State, And Zip Code | | 15a. Last Name Before First Marriage | | 16. Decedent's Usual Occupation | |
| DYER, IN 46311 | | LAKE | | 17. Kind Of Business/Industry | |
| 18. Residence - State | | 19a. Country | | 19b. City Or Town | |
| INDIANA | | LAKE | | LCWELL | |
| 19c. Street And Number | | 19d. Apt. No. | | 19e. Zip Code | |
| 7404 WEST 205TH AVENUE | | | | 46356 | |
| 19f. Inside City Limits? | | | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |

| | | | |
|---|--|---|--|
| 20. Decedent Of Hispanic Origin | | 21. Decedent's Race | |
| NOT HISPANIC | | White | |
| 22. Parent's Name (First, Middle, Last) | | 23. Parent's Name (First, Middle, Last) | |
| JAMES ROBERT OWENS | | RUE Y MARIE KUJAWSKI | |
| 24a. Relationship To Decedent | | 24b. Mailing Address (Street And Number, City, State, Zip Code) | |
| SPOUSE | | 7404 WEST 205TH AVENUE, LOWELL, IN 46356 | |

| | | | | | |
|---|--|--|--|---------------------------------------|--|
| 25a. Method Of Disposition | | 25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place) | | 25c. Location - City, Town, And State | |
| <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment | | GEISEN CREMATION CENTRE | | CROWN POINT, IN | |
| 26. Was Coroner Contacted? | | 27. Name And Complete Address Of Funeral Facility | | 27a. Funeral Home License Number | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | SHEETS FUNERAL HOME AND CREMATION SERVICES, 604 E. COMMERCIAL AVENUE, LOWELL, IN 46356 | | FH83004277 | |
| 28. Signature Of Indiana Funeral Services Licensee | | 27c. License Number (Of Licensee) | | | |
| JENNIFER LYNN OSBURN, BY ELECTRONIC SIGNATURE | | FD21300013 | | | |

| | | | |
|---|--|-------------------------------------|--|
| 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 Venous/Arterial Puncturing Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On Line A. Add Additional Lines If Necessary. | | Approximate Interval: Days To Death | |
| Immediate Cause (Final Disease Or Condition Resulting In Death) | | DAYS | |
| A. ACUTE HYPOXIC RESPIRATORY 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 | | DAYS | |
| B. RIGHT SIDED PNEUMOTHORAX | | | |
| C. METASTATIC PROSTATE CANCER | | WEEKS | |
| D. | | | |

| | | | |
|---|--|--|--|
| 29. Was an Autopsy Performed? | | 30. Were Autopsy Findings Available To Complete The Cause Of Death? | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 31. Was Autopsy Findings Available To Complete The Cause Of Death? | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 32. If Female: | | 33. Manner Of Death: | |
| <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 Within 42 Days Of Death | | <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation | |
| 34. Date Of Injury (Month/Day/Year) | | 35. Time Of Injury | |
| | | | |
| 36. Location Of Injury - State | | 36a. City Or Town | |
| | | | |
| 36b. Street & Number | | 36c. Apt. No. | |
| | | | |
| 36d. Zip Code | | | |
| | | | |

| | | | |
|--|--|---|--|
| 37. Describe How Injury Occurred | | 38. If Transportation Injury Specify | |
| | | <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) | |
| 41. Signature Of Person Certifying Cause Of Death: | | 42. Center (Check Only One) | |
| ABDUL RAHMAN BAIG, BY ELECTRONIC SIGNATURE | | <input checked="" type="checkbox"/> Certifying Physicians <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer | |
| 43. Name, Address And Zip Code Of Person Certifying Cause Of Death | | 44. License Number | |
| ABDUL RAHMAN BAIG, 5454 HOHMAN AVENUE, HAMMOND, IN 46320 | | 02075654A | |
| 46. Additional Funeral Service Provider | | 45. Date Certified | |
| | | 07/25/2018 | |

| | | | |
|---|--|---|--|
| 48. Signature Of Local Health Officer: | | 49. For Registrar Only - Date Filed (Month/Day/Year): | |
| CHANDANA VAVILALA, VIA ELECTRONIC SIGNATURE | | JUL 26 2018 | |
| AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL) | | JUL 26 2018 | |

THIS IS A TRUE COPY OF
 AMENDMENT 5690 ON FILE WITH THE
 LAKE COUNTY HEALTH DEPARTMENT
 JUL 26 2018
 LAKE COUNTY HEALTH OFFICER

NOT VALID UNLESS