

92038152

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA

COUNTY OF LAKE

S. S.

On this 1st of May 1992 before me personally appeared

Carol A. Scherry

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is Joint Owner (state interest of affiant in the above premises as "owner," "son of owner," etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by George John Scherry and Carol A. Scherry

4. Said George John Scherry AKA GEORGE J. SCHERRY (fill in name of co-tenant who died)

died on January 29, 1991

leaving no will (insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is

Lot 101, Plum Creek Village 6th Addition, Block 3, to the Town of Schererville, as shown in Plat Book 62, page 26, in Lake County, Indiana

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent.

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:)

8. Affiant's relationship to the deceased was wife

Signature: Carol A. Scherry
Carol A. Scherry
Address: 305 Plum Creek Drive
Schererville, IN 46375

Subscribed and sworn to before me by the affiant

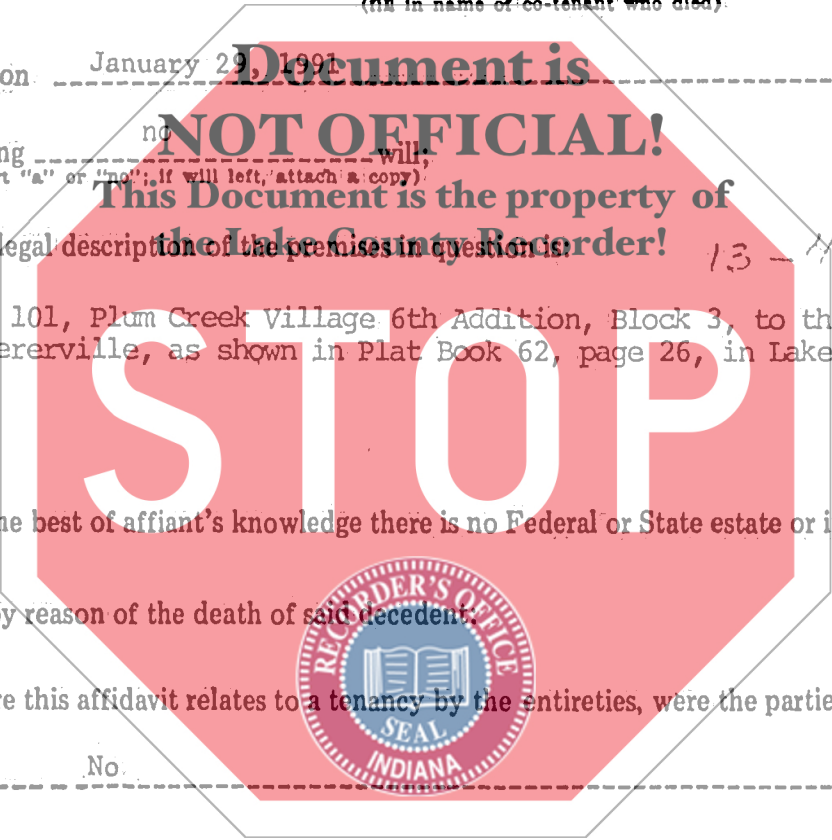
this May 1, 1992 (insert date)

Jan McGrath Notary Public

My Commission Expires 8/5/94

County of Residence: Lake

This instrument prepared by Carol A. Scherry



FILED

JUN 1 1 1992

Anna M. Antox AUDITOR LAKE COUNTY

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CHICAGO TITLE INSURANCE COMPANY INDIANA DIVISION STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. 216-91

Local No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

ALTH OFFICER

DRONER USE ONLY

1. DECEASED - NAME (First, Middle, Last) <b>George John Scherry [aka Winniowski]</b>				2. SEX <b>Male</b>	3. TIME OF DEATH <b>10:05a m</b>	3a. DATE OF DEATH (Month, Day, Year) <b>January 29, 1991</b>
4. SOCIAL SECURITY NUMBER <b>324-34-4571</b>		5a. AGE - Last Birthday (Years) <b>48</b>	5b. UNDER 1 YEAR Months Days	6. UNUSUAL CIRCUMSTANCES MURDER	8. DATE OF BIRTH (Month, Day, Year) <b>March 3, 1942</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Illinois</b>
6a. WAS DECEASED A U.S. VETERAN? <b>No</b>	6b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>-</b>	9. PLACE OF DEATH (Check any one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Other (Specify)		10. FACILITY NAME (If not institution, give street and number) <b>St. Anthony Hospital</b>		
11. SURVIVING SPOUSE (If wife, give maiden name) <b>Carol A. Pietrzak</b>			12a. DECEASED'S USUAL OCCUPATION (Oversend of work done during most of working life. Do not use initials) <b>Draftsman</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Engineering Company</b>	
13a. RESIDENCE - STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN OR LOCATION <b>Schererville</b>		13d. STREET AND NUMBER <b>305 Plum Creek Drive</b>
13e. ZIP CODE <b>46375</b>	13f. IN OR OUT OF CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEASED OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE - American Indian, Black, White, etc. (Specify) <b>White</b>	17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5-6)	
18. FATHER'S NAME (First, Middle, Last) <b>John George Wisniowski</b>			19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine Milkowski</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Carol A. Scherry</b>			20b. ADDRESS (Street, City or Town, State, Zip Code) <b>305 Plum Creek Dr., Schererville, IN 46375</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>February 2, 1991 Holy Cross Cemetery</b>		21c. LOCATION - City or Town, State <b>Calumet City, Illinois</b>		
22a. EMBALMER'S NAME <b>Larry D. Anthony</b>		22b. EMBALMER'S LICENSE NO. <b>01001447</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		24b. LICENSE NUMBER (of Licensee) <b>01001447</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Anthony &amp; Dziadowicz F.H. 83002916 9445 Calumet Ave, Munster, IN 46321</b>		
26. PART I - Enter the disease, injuries, or conditions that caused the death. Do not enter nonspecific terms, such as natural or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>cardiac arrest</b> <b>Multiple Myeloma</b> <b>schlemic dilated cardiomyopathy</b>						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
26. PART II - Other significant conditions - Conditions contributing to death but not previously stated in Part I.						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
27. WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>-</b>		
29a. CERTIFYING OFFICER'S SIGNATURE AND TITLE (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>V.R. Brander</i>				29c. MEDICAL LICENSE NO. <b>29999</b>	29d. DATE SIGNED (Month, Day, Year) <b>January 30, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) <b>Vidyadhar Gandra, M.D., 297 Franciscan Dr., Crown Point, IN 46307</b>						
31. HEALTH OFFICER'S SIGNATURE <i>Robert Lutzke, M.D.</i>						32. DATE FILED (Month, Day, Year) <b>January 30, 1991</b>
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED	
34e. PLACE OF INJURY - At home, farm, street, factory, office, building, etc. (Specify)			34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.				

INDIANA TITLE INSURANCE CORPORATION

