

93016154 SURVIVORSHIP AFFIDAVIT FILED

STATE OF Indiana } S. S.
COUNTY OF Lake

MAR 11 1993

Anna N. Anton
AUDITOR LAKE COUNTY

On this March 2, 1993 before me personally appeared
(Insert date)

Peter Dittrich

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 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
Peter Dittrich and Eileen Dittrich;

4. Said Eileen Dittrich AKA EILEEN LOUISA DITTRICH
(fill in name of co-tenant who died)

died on October 10, 1992

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

5. The legal description of the premises in question is:
Lot 14, Pheasant Hills Addition, Unit 6, Block T, the town of Dyer, as shown in Plat Book 44, page 49, 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 Husband

Signature: *Peter Dittrich*
Peter Dittrich

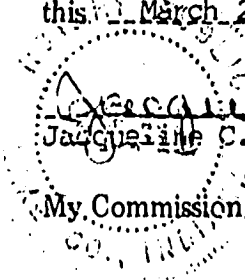
Address: 2307 Peach Tree Ln., Dyer, IN 46311

Subscribed and sworn to before me by the affiant

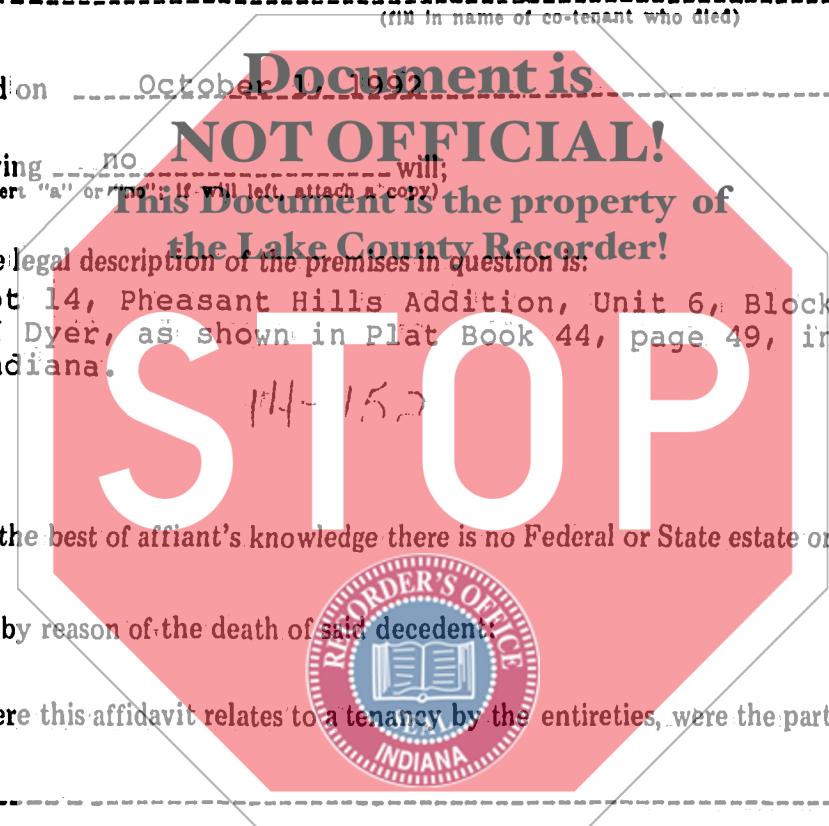
this March 2, 1993
(insert date)

Jacqueline C. Carey
Jacqueline C. Carey Public

My Commission Expires 3/11/96



This instrument prepared by Clement B. Knapp, Jr., Attorney at Law



STATE OF INDIANA/S.S. SO.
LAKE COUNTY
FILED FOR RECORD
MAR 12 1 05 PM '93
SAMUEL ORLICH
RECORDER

00475

800 CT

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 2063-92

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) Eileen Louisa Dittrich				2 SEX Female		3a TIME OF DEATH 6:00 A		3b DATE OF DEATH (Month Day, Yr) October 1, 1992							
4 SOCIAL SECURITY NUMBER 343-50-6105		5a AGE—Last Birthday (Years) 38		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo Day, Yr) June 3, 1954		7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? No		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER—Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence											
9b FACILITY NAME (If not institution, give street and number) Community Hospital				9c CITY TOWN OR LOCATION OF DEATH Munster				9d COUNTY OF DEATH Lake							
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Peter Dittrich		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker				12b KIND OF BUSINESS/INDUSTRY Home							
13a RESIDENCE—STATE IN		13b COUNTY Lake		13c CITY TOWN OR LOCATION Dyer				13d STREET AND NUMBER 2307 Peachtree Ln.							
13e ZIP CODE 46311		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16 RACE—American Indian, Black, White, etc. (Specify) White		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) 12					
18 FATHER'S NAME (First Middle Last) Russell Perrone						19 MOTHER'S NAME (First Middle Maiden Surname) Louisa Giaccaglia									
20a INFORMANT'S NAME (Type/Print) Peter Dittrich				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2307 Peachtree Ln, Dyer, IN 46311				20c Relationship Husband							
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) October 3, 1992 Chapel Lawn Memorial Gardens				21c LOCATION—City or Town, State Scherville, IN							
22a EMBALMER'S NAME James Porras				22b EMBALMER'S LICENSE NO. 1045964				23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes							
24a SIGNATURE OF FUNERAL DIRECTOR Thomas J. Burns				24b LICENSE NUMBER (of Licensee) 1045184				25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321							
26 (PART I) Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death): a. <u>Metastatic breast cancer</u> b. _____ c. _____ d. _____ Conditions if any, which gave rise to the immediate cause, stating the underlying cause last: e. _____ f. _____										Approximate Interval Between Onset and Death:					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I										27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) ---	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, 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>Robert Taylor</i>				29c MEDICAL LICENSE NO. 27970		29d DATE SIGNED (Month Day, Year) Oct. 2, 1992							
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If 1A 2b) (Type/print) S.D. Gailani, M.D. 9116 Columbia Ave. Munster, IN 46321										31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>		DATE SIGNED (Month Day, Year) October 2, 1992			
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 PLACE OF INJURY (If home, farm, street, factory, office, building, etc. (Specify))		34d MOTOR VEHICLE ACCIDENT? (Yes or no) FILE MAR 11 1993							
34g DATE PRONOUNCED DEAD (Month Day Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) <i>David M. Entow</i> MUNSTER, LAKE COUNTY											

DECEDENT

PARENTS

INFORMANT

DISPOSITION

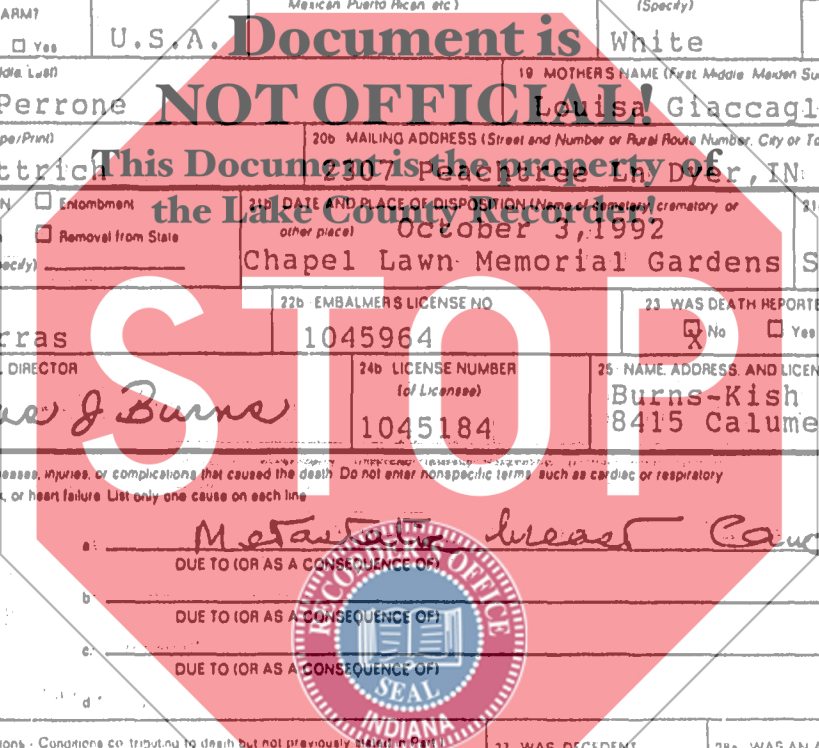
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

April 14-152-14 Lot 14 PHEASANT HILLS Add. Unit 6 Bl. 2



Indiana Life Insurance Company