FILED

APR 22 1993

AUDITOR LAKE COUNTY

SURVIVORSHIP AFFIDAVIT

93025713

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

On this March 17, 1993, before me personally appeared Rudell M. DiCianni to me personally known, who being duly sworn on oath deposes and says:

1. Affiant resides at the address given below affiant's signature.

2. Affiant is wife and surviving tenant by entireties.

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Anthony A. DiCianni and Rudell M. DiCianni.

4. Said Anthony A. DiCianni died on January 1, 1993 leaving a will;

5. The legal description of the premises in question is:

Lots 16 and 17, Whiting's a subdivision of part of the Southwest Quarter of the Northeast Quarter of Section 7, Township 37 North, Range 9 West of the 2nd Principal Meridian, City of Whiting, Plat Book 2, page 52, Lake County, Indiana, more commonly known as 1312 119th Street, Whiting, Indiana. Real Estate Tax Key 29-115-15 and 29-115-16.

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: Not applicable.

8. Affiant's relationship to the deceased was wife, surviving spouse.

APR 23 9 00 AM '93
SABUCH JURLICH
RECORDER

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD

Rudell M. DiCianni
RUDELL M. DiCianni
11036 Stateline Road
Chicago, Illinois 60617

Subscribed and sworn to before me by the affiant this March 17, 1993.

Notary Public
KENNETH A. MANNING

My Commission expires:
12-12-94

Resident of Lake County

01129

This Instrument Prepared by: Kenneth A. Manning, Atty. 200 Monticello Dyer, Indiana 46311

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Jun 4, 1993
State Date Issued — Health and Hospital Commissioner

Local No. .....

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): Anthony A Diciannì
2. SEX: Male
3a. TIME OF DEATH: 4:15 PM
3b. DATE OF DEATH (Month Day Yr): January 1, 1993
4. SOCIAL SECURITY NUMBER: 324-22-5024
5a. AGE—Last Birthday: (66)
5b. UNDER 1 YEAR: Months Days
5c. UNDER 1 DAY: Hours Minutes
6. DATE OF BIRTH (Mo Day Yr): July 8, 1929
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? NONE
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution give street and number): St. Margaret Hospital
9c. CITY, TOWN OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS: Married
11. SURVIVING SPOUSE: Rudell Blackard
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Owner Center Lounge
12b. KIND OF BUSINESS/INDUSTRY: Tavern
13a. RESIDENCE—STATE: Illinois
13b. COUNTY: Cook
13c. CITY, TOWN OR LOCATION: Chicago
13d. STREET AND NUMBER: 11036 Stateline Rd.
13e. ZIP CODE: 60617
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. (If a farm) ☐ No ☐ Yes
14. CITIZEN OF: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? XXX No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc.: White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): Leo d Diciannì
19. MOTHER'S NAME (First Middle Maiden Surname): Margaret A Demarco

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Rudell Diciannì
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11036 Stateline Rd. Chicago Il. 60617
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): 1/5/93 St. Mary Cemetery January
21c. LOCATION—City or Town, State: Evergreen Park, Il.
22a. EMBALMER'S NAME: James F Betkowski
22b. EMBALMER'S LICENSE NO: 09200077
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: James F Betkowski
24b. LICENSE NUMBER (of Licensee): 09200077
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Baran & Son, Inc FDH 83007267 1235 119TH St Whiting In. For Elmwood Chapel FH Chicago, Il.

CAUSE OF DEATH

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) Advanced lung cancer
DUE TO (OR AS A CONSEQUENCE OF):
b)
DUE TO (OR AS A CONSEQUENCE OF):
c)
DUE TO (OR AS A CONSEQUENCE OF):
d)

Approximate Interval Between Onset and Death

Conditions if any, which gave rise to the immediate cause stating the underlying cause last:

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
AUTOPSY PERFORMED? (Yes or no): No
28. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): NO

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date and place and due to the cause(s) as stated
☐ 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
☐ 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:
29c. MEDICAL LICENSE NO: 29762
29d. DATE SIGNED (Month, Day, Year): Jan 11/4/93

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print): Dr. M Y Ali 9116 Columbia Ave. Munster, IN 46321
31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): January 4, 1993

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.:

01130

SDH06-004 State Form 10110 (R/1-92) DEATHCER/PD 1