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SURVIVORSHIP AFFIDAVIT

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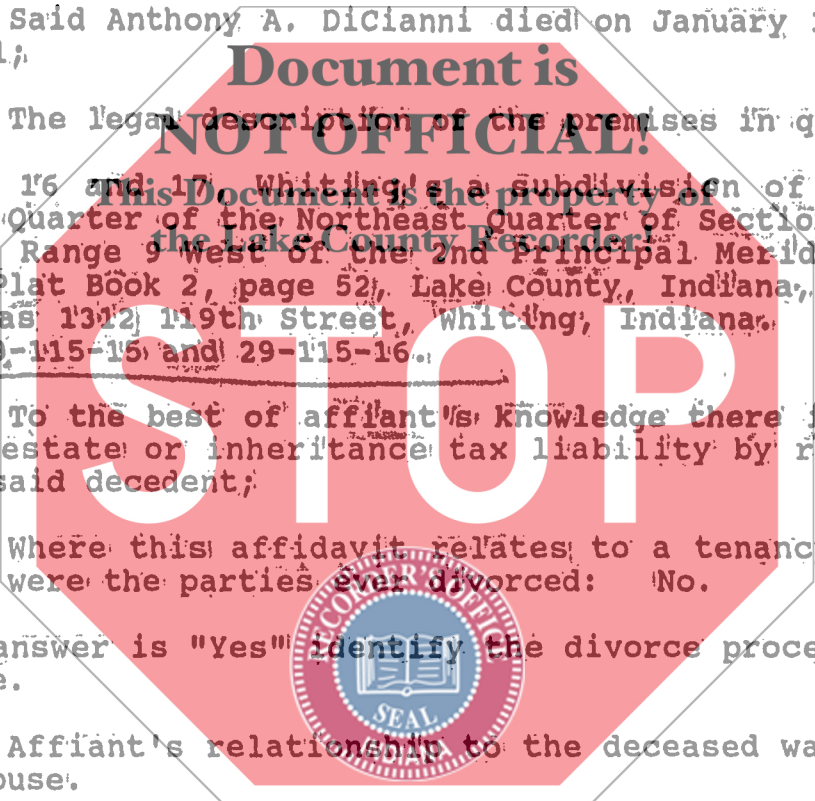
STATE OF INDIANA
COUNTY OF LAKE

SS:

Alan N. Carter
AUSTIN LAKE COUNTY

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, 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.



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

STATE OF INDIANA/S.S.NO.
 LAKE COUNTY
 FILED FOR RECORD
 APR 23 9 00 AM '93
 SAMUEL UNLICH
 RECORDER

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

Kenneth A. Manning
 Notary Public
 KENNETH A. MANNING
 Resident of Lake County
 01129

My Commission expires:
12-13-94

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

J. W.

INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

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: Hammond Health Commissioner

Local No.

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT:

PARENTS

INFORMANT

DISPOSITION:

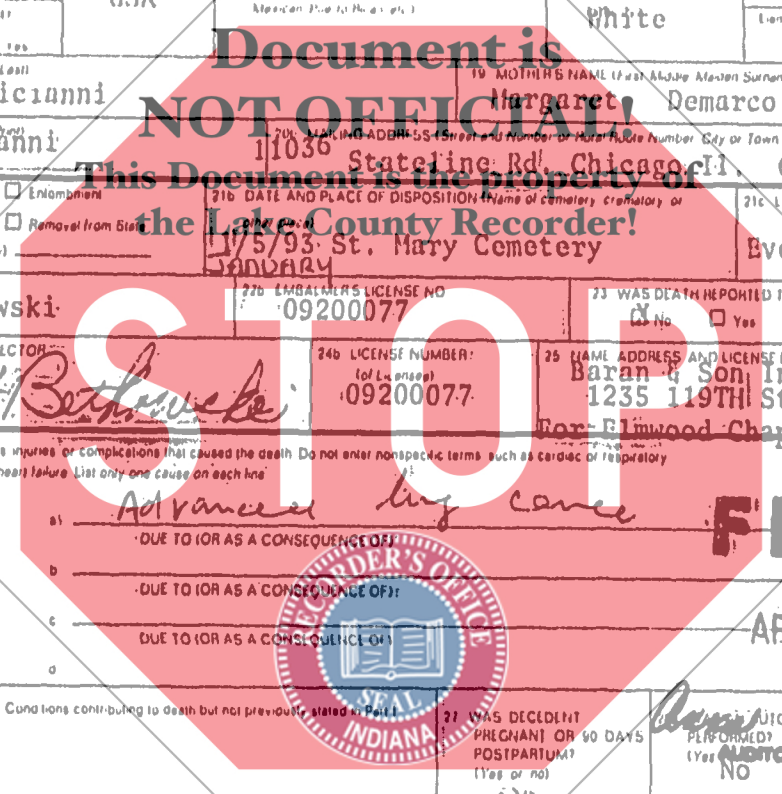
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER:

CORONER USE ONLY

1 DECEASED—NAME (First Middle Last) Anthony A Dicianni		2 SEX Male	3a TIME OF DEATH 4:15 P.M.	3b DATE OF DEATH (Month Day Yr) January 1, 1993
4 SOCIAL SECURITY NUMBER 324-22-5024		5a AGE—Last Birthday 166	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 US VETERAN? no	8b YEAR LAST SERVED IN US ARMED FORCES? None	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
10 FACILITY NAME (if not institution give street and number) St. Margaret Hospital		11 CITY, TOWN OR LOCATION OF DEATH Hammond	12 COUNTY OF DEATH Lake	
10a MARITAL STATUS Married	11 SURVIVING SPOUSE Rudell Stackard	12a DECEDENT'S USUAL OCCUPATION (Give kind of work if not 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 <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF USA	15 WAS DECEDENT OF HISPANIC ORIGIN? XXX No <input type="checkbox"/> Yes <input type="checkbox"/> (If yes specify father's name)	16 RACE—American Indian, Black, White, etc. White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 12		18 DECEDENT'S EDUCATION (Elementary Secondary (10-12) College (14 or 16))		
18 FATHER'S NAME (First Middle Last) Leo d Dicianni		19 MOTHER'S NAME (First Middle Maiden Surname) Margaret Demarco		
20a INFORMANT'S NAME (Last, First, Middle) Rudell Dicianni		20b WORKING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11036 Stateline Rd, Chicago, IL 60617	20c Relationship Wife	
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) 1/5/93 St. Mary Cemetery		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? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24 SIGNATURE OF FUNERAL DIRECTOR <i>James F Betkowski</i>		24b LICENSE NUMBER (of License) 09200077	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Baran & Son, Inc PH# 83007267 1235 119TH St Whiting In. For Elmwood Chapel, IL Chicago, IL	
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. Advanced by cancer				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a) Advanced by cancer b) DU TO (OR AS A CONSEQUENCE OF) c) DU TO (OR AS A CONSEQUENCE OF) d) DU TO (OR AS A CONSEQUENCE OF)				
Conditions if any which give 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		28 AUTOPSY PERFORMED? (Yes or no) NO		29 AUDITOR LAWS CONVICTION OF CAUSE OF DEATH? (Yes or no) NO
28a 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>M Y Alt</i>		
29c MEDICAL LICENSE NO. 29762		29d DATE SIGNED (Month Day Year) Jan 11/4/93		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Dr. M Y Alt 9116 Columbia Ave. Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Adam J. J. Remuda, M.D.</i>				32 DATE FILED (Month Day Year) January 4, 1993
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 PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e LOCATION (Street and Number or Rural Route Number, City or Town, State)		
34f DESCRIBE HOW INJURY OCCURRED:				
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		



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