474233 XD 5064 Bk of Nyc, Nyc

Chicago Title Insurance Company

94025614 SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
COUNTY OF LAKE } S. S.

On this March 26, 1994 (insert date) before me personally appeared CARL E. Waschke

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 Clora A. Reed Life Estate and Carl E. Waschke Owner
4. Said Clora A. Reed AKA CLORA ALICE REED (fill in name of co-tenant who died)
   died on February 3, 1994
   leaving a will; (insert "a" or "no"; if will left, attach a copy)
5. The legal description of the premises in question is:
   Lot 31 Except the 14 feet by Parallel lines off the entire Southeasterly side thereof and the Southeasterly 5 feet by parallel lines of Lot 32 Block 4, Hollywood of Hammond, in the Town of Munster, as shown in PB 19, pg 21, in LAKE County, IN
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 nephew

FILED
APR 5 1994

Signature: Carl E. Waschke
CARL E. WASCHKE

Anna N. Anton

Address: 7712 Manor Av.
Munster IN. 46321

Subscribed and sworn to before me by the affiant
this 31st Day of March, 1994 (insert date)

Margaret J. Ortell
Notary Public

MARGARET J ORTELL
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY
MY COMMISSION EXP JULY 6,1996

My Commission Expires ----------

This instrument prepared by Carl E. Waschke

APR 6 10 18 AM '94
SAM RECORDER
FILED FOR RECORD
LAKE COUNTY, IND.

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ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. C336-94

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

Field	Value
1 DECEASED—NAME (First Middle Last)	Clora Alice Reed
2 SEX	Female
3a TIME OF DEATH	9:45 a.m.
3b DATE OF DEATH (Month Day Yr)	February 2, 1994
4 *SOCIAL SECURITY NUMBER	333 07 4269
5a AGE—Last Birthday (Years)	95
5b UNDER 1 YEAR (Months, Days)	
5c UNDER 1 DAY (Hours, Minutes)	
6 DATE OF BIRTH (Mo. Day Yr)	March 15, 1898
7 BIRTHPLACE (City and State or Foreign Country)	Belleville, Illinois
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)	7712 Manor Drive
9c CITY, TOWN OR LOCATION OF DEATH	Munster
9d COUNTY OF DEATH	Lake
10 MARITAL STATUS (Specify)	Widowed
11 SURVIVING SPOUSE (If wife, give maiden name)	none
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	Own Home
13a RESIDENCE—STATE	Indiana
13b COUNTY	Lake
13c CITY, TOWN OR LOCATION	Munster
13d STREET AND NUMBER	7712 Manor Drive
13e ZIP CODE	46321
13f INSIDE CITY LIMITS	☐ No ☒ Yes
13g ON A FARM?	☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?	U.S.A.
15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc.)	☒ No ☐ Yes
16 RACE—American Indian, Black, White, etc. (Specify)	White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	12
College (1-4 or 5+)	

PARENTS

Field	Value
18 FATHER'S NAME (First Middle Last)	Thomas Jones
19 MOTHER'S NAME (First Middle Maiden Surname)	Sarah N/A

INFORMANT

Field	Value
20a INFORMANT'S NAME (Type/Print)	Dorothy Piwowar
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7824 W. 66th Place, Argo, Illinois 60501
20c Relationship	Niece

DISPOSITION

Field	Value
21a METHOD OF DISPOSITION	☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	February 7, 1994 Mt. Emblem Cemetery
21c LOCATION—City or Town, State	Elmhurst, Illinois
22a EMBALMER'S NAME	James Porras
22b EMBALMER'S LICENSE NO.	1045964
23 WAS DEATH REPORTED TO CORONER?	☐ No ☒ 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 #3002819 5810 Hohman Ave/ Hallowell & James F H Hammond, Indiana/LaGrange, Illinois

CAUSE OF DEATH

28 PART I Enter the diseases, 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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) a.	Acute Congestive Heart Failure	Hours
DUE TO (OR AS A CONSEQUENCE OF) b.	Chronic Congestive Heart Failure	Months
DUE TO (OR AS A CONSEQUENCE OF) c.		
DUE TO (OR AS A CONSEQUENCE OF) d.		

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: Cardiac Arrhythmia

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):

FILED APR 5 1994

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.

Anna M. Antos

29b SIGNATURE AND TITLE OF CERTIFIER: [signature] D.O.

29c MEDICAL LICENSE NO.: 02000209

29d DATE SIGNED (Month Day Year): February 7, 1994

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print): Dr. C. Foreit, 3831 Hohman Ave, Hammond, Indiana

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.

32 DATE FILED (Month Day Year): February 7, 1994

Field	Value
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.	

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SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1