

94025614 SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA } S. S.
COUNTY OF LAKE }

On this March 26, 1994 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
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Clora A. Reed L. E. Esch and Carl E. Waschke Owner
4. Said Clora A. Reed AKA CLORA ALICE REED

died on February 3, 1994
leaving a will;

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 line
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?
NU

8. Affiant's relationship to the decedent was nephew

FILED

APR 5 1994

Signature: Carl E. Waschke
CARL E. WASCHKE

Address: 7712 Manor Ave
Munster IN. 46321

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

Margaret J. Ortell
Notary Public

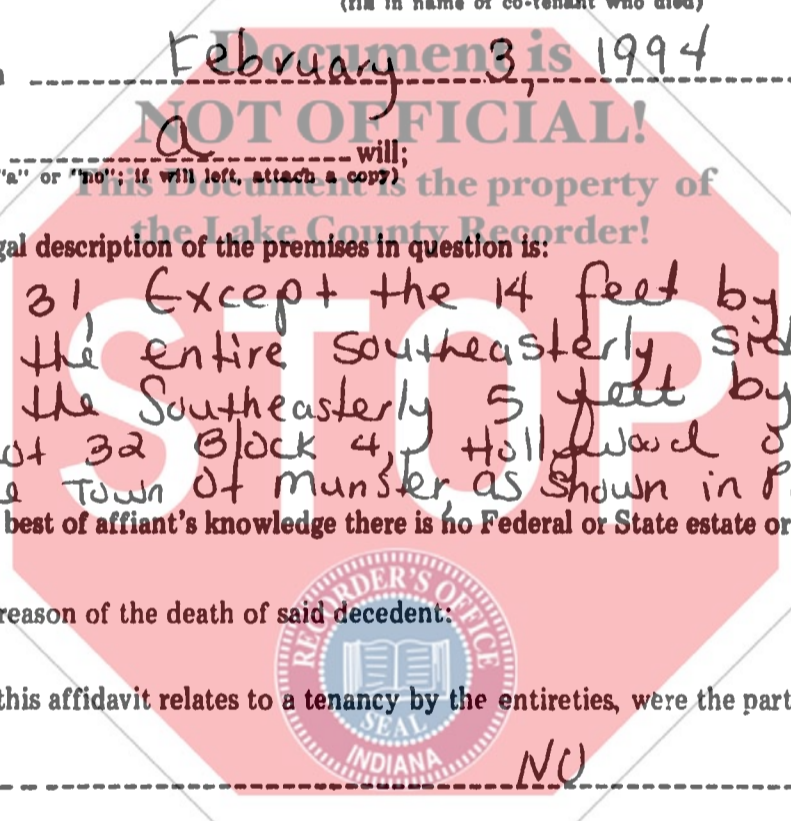
MARGARET J ORTELL
NOTARY PUBLIC STATE OF INDIANA
LAKE COUNTY
MY COMMISSION EXP JULY 6, 1996

My Commission Expires

This instrument prepared by Carl E. Waschke

Chicago Title Insurance Company
LAKE COUNTY
FILED FOR RECORD

APR 6 10 18 AM '94
S.A. RECORDER



NOT OFFICIAL!

This Document is the property of the Lake County Recorder!

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. C336-94

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

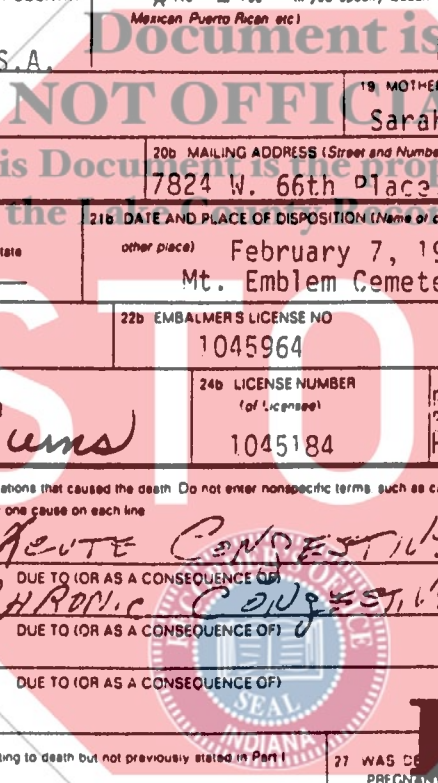
DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

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 Year) February 7, 1994
4 SOCIAL SECURITY NUMBER 333 07 4269	5a AGE—Last Birthday (Year) 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 US VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? none	8c PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a 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 <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12		College (11-4 or 8+)		
18 FATHER'S NAME (First Middle Last) Thomas Jones		19 MOTHER'S NAME (First Middle Maiden Surname) Sarah N/A		
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
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) 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? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of licensee) 1045184		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #2002819 5840 Hohman Ave/Hallowell & James F H Hammond Indiana/LaGrange, Illinois
28 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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) ACUTE CONGESTIVE HEART FAILURE HOURS				
DUE TO (OR AS A CONSEQUENCE OF) CHRONIC CONGESTIVE HEART FAILURE MONTHS				
DUE TO (OR AS A CONSEQUENCE OF)				
DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
Cardiac Arrhythmia			27 WAS DECEDENT PREGNANT OR 30 DAYS POSTPARTUM? (Yes or no) no APR 6 1994	
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)				
29a CERTIFIER <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) as stated.				
29b SIGNATURE AND TITLE OF CERTIFIER <i>Anna M. Doctor</i>		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				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Killings</i>				31b DATE FILED (Month Day Year) February 7, 1994
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		



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