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FA- 11941

94029518

RETURN TO:
FIRST AMERICAN TITLE INS. CO.
5265 COMMERCE DR. SUITE 1
CROWN POINT, IN 46307

Property Address: 947 N. Arbogast

Griffith, IN 46319

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

SANDRA L. REITZ, Affiant, states that:

APR 19 9 53 AM '94
RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

1. Fred W. Reitz, deceased, died on the 8 day of February, 1993;

2. Affiant is: ✓ the surviving spouse of the deceased,

___ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ___ leaving a will which has been probated;

___ leaving a will which has not been probated;

✓ leaving no will;

4. The deceased and Affiant were married on the 14 day of October, 1961; and were never divorced.
(This item applies only to the surviving spouse.)

FILED
APR 19 1994
Alex N. Anton
AUDITOR LAKE COUNTY

5. ✓ All expenses of the last illness and funeral of the deceased have been paid;

6. ✓ All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. ✓ There are no claims against the estate of the decendent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

04/14/94
Date

Sandra L. Reitz
Signature of Affiant SANDRA L. REITZ

SANDRA L. REITZ
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 14th day of April, 1994.

BETH A. KOLBERT
Printed Name of Notary

Beth A. Kolbert
Signature of Notary

My Commission expires: 07/11/97

My County of Residence is: LAKE, COUNTY, IN

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FA-11941

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 0280-93

State No.

RETURN TO:
FIRST AMERICAN TITLE INS. CO.
5265 COMMERCE DR. SUITE 1
CROWN POINT, IN 46307

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last): Fred W. Reitz
2. SEX: Male
3a TIME OF DEATH: 5:45 PM
3b DATE OF DEATH (Month Day Yr): February 8, 1993
4 SOCIAL SECURITY NUMBER: 332-32-1240
5a AGE—Last Birthday (Years): 52
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Mo. Day. Yr): Dec. 11, 1940
7 BIRTHPLACE (City and State or Foreign Country): Chicago, Illinois
8a WAS DECEDENT A U.S. VETERAN?: YES
8b YEAR LAST SERVED IN U.S. ARMED FORCES?: UNK
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution give street and number): The 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): Sandy Schultz
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Interstate Brands
12b. KIND OF BUSINESS/INDUSTRY: Union
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Griffith
13d. STREET AND NUMBER: 947 N. Arbogast
13e ZIP CODE: 46319
13f INSIDE CITY LIMITS: [ ] No [X] Yes
13g ON A FARM?: [X] No [ ] Yes
14 CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: [X] No [ ] 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 (0-12): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): James Reitz
19 MOTHER'S NAME (First, Middle, Maiden Surname): Geneiveve Obereitter

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sandy Reitz
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 947 N. Arbogast Griffith, Indiana
20c. Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): February 11, 1993 Chapel Lawn Cemetery
21c. LOCATION—City or Town, State: Schererville, Indiana
22a EMBALMER'S NAME: Ronald A. Reed
22b EMBALMER'S LICENSE NO.: FDO 1001081
23 WAS DEATH REPORTED TO CORONER?: [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: G. Kuiper
24b LICENSE NUMBER (of Licensee): FDO 1014511
25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500

CAUSE OF DEATH

26. 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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Pneumonia due to pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):

Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last.

PART II. Other significant 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)

FILED
APR 1 1993
AUDITOR LAKE COUNTY

CERTIFIER

29a CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner 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: [illegible] M.D.
29c. MEDICAL LICENSE NO: IND 0703451
29d. DATE SIGNED (Month, Day, Year): 2/9/93

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Don H. Dumont 761 45th St. Suite Munster IN 46321 M.D.
31. HEALTH OFFICER'S SIGNATURE: [illegible] M.D.
32. DATE FILED (Month, Day, Year): Feb. 10, 1993

CORONER USE ONLY

33 MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Suicide [ ] Homicide [ ] Pending Investigation [ ] Could not be Determined
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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