

FA: 15351

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95 SEP -7 AM 10:06

Property Address: 1518 Fischrupf
Whiting, IN 46394

MARGARETE STEVENS
RECORDER

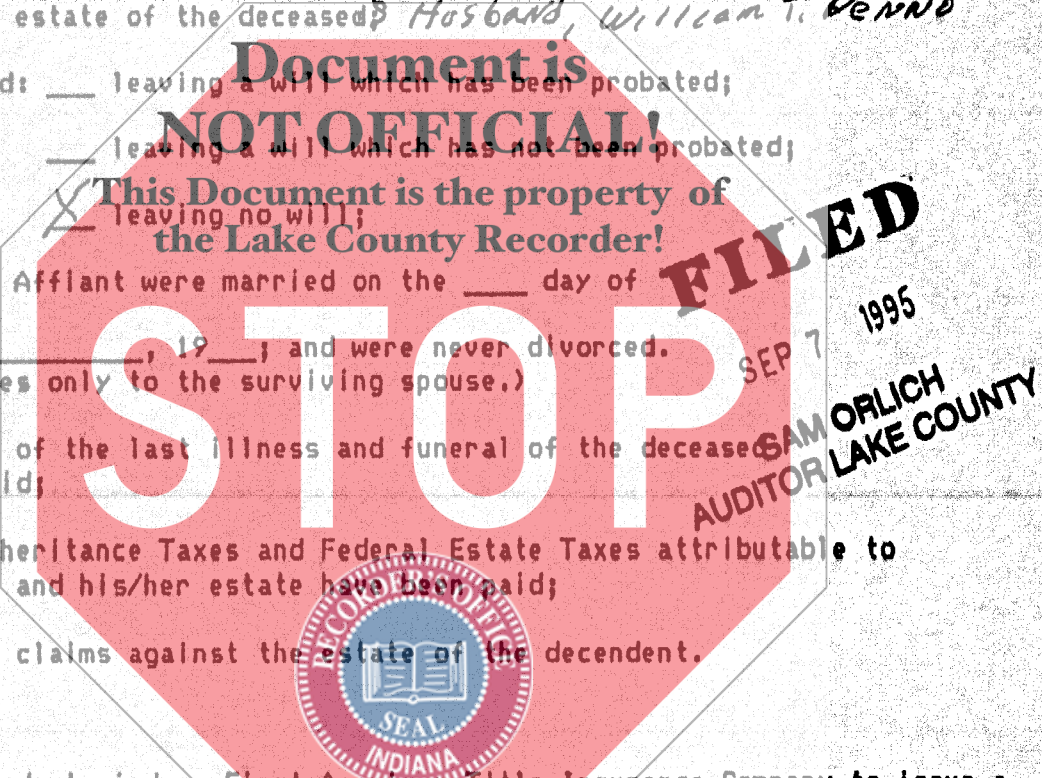
HOLD FOR FIRST AMERICAN TITLE

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

ESTATE AFFIDAVIT

Sandra M. Nissen, Affiant, states that:

- Doris Jean Denno, deceased, died on the 18th day of November, 1991;
- Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the estate of the deceased Husband, William T. Denno
- The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;
- The deceased and Affiant were married on the day of , 19 ; and were never divorced.
(This item applies only to the surviving spouse.)
- All expenses of the last illness and funeral of the deceased have been paid;
- All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;
- There are no claims against the estate of the decedent.



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

August 28, 1995
Date

Sandra M. Nissen
Signature of Affiant

Sandra M. Nissen
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 28th day of August, 1995

Beth A. Kolbert
Printed Name of Notary

Beth A. Kolbert
Signature of Notary

My Commission expires: July 11, 1997

My County of Residence is: Lake

000348

Prepared By: Sandra M. Nissen

Legal Description: Lot 27 and the east half of Lot 28 in Harvey's Subdivision, to the City of Whiting, as per plat thereof, recorded in Plat Book 2, Page 34, in the office of the recorder of Lake County, Indiana.

11/01
FA

PA 15351
Local No. 358

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No.

HOLD FOR FIRST AMERICAN
TITLE TYPE/PRINT
IN PERMANENT
BLACK INK

PARENTS
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER
USE ONLY

1. DECEASED—NAME (First, Middle, Last) DORIS JEAN DENNO		2. SEX FEMALE	3a. TIME OF DEATH 7:21A M	3b. DATE OF DEATH (Month, Day, Yr) NOVEMBER 18, 1991
4. SOCIAL SECURITY NUMBER NOT AVAILABLE	5a. AGE—Last Birthday 68	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) JUNE 26, 1925
7. BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA		8a. WAS DECEDENT VETERAN? NO		
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) ST. CATHERINE HOSPITAL		9b. CITY, TOWN, OR LOCATION OF DEATH EAST CHICAGO		9c. COUNTY OF DEATH LAKE
10. MARITAL STATUS MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) WILLIAM T. DENNO	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 WHITING	13d. STREET AND NUMBER 1518 FISCHRUPP AVENUE	
13e. ZIP CODE 46394	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	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, White, etc. (Specify) WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+)				
18. FATHER'S NAME (First, Middle, Last) DWAYNE HUNT		19. MOTHER'S NAME (First, Middle, Maiden Surname) MILDRED LEE		
20a. INFORMANT'S NAME (Type/Print) WILLIAM T. DENNO		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 FISCHRUPP AVE, WHITING, IN 46394		20c. Relationship HUSBAND
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) CHAPEL LAWN CEMETERY		21c. LOCATION—City or Town, State SCHERERVILLE, IN
22a. EMBALMER'S NAME THOS. OWENS		22b. EMBALMER'S LICENSE NO. FDE 1001049		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thos Owens</i>		24b. LICENSE NUMBER FDE 1001049		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME OWENS FUNERAL HOME, 816-119 St., Whiting, IN 46394
25. 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. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF)		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. CONAL FAILURE SEMI COMA		27. WAS DECEDENT PREGNANT OR 90 DAYS POST PARTURITION? (Yes or no) NO		28. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A
29a. 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>George T. Asteris</i>		29c. MEDICAL LICENSE NO. 01027468		29d. DATE SIGNED (Month, Day, Year) 11/21/91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) GEORGE T. ASTERIS 2450-169th ST. HAMMOND, INDIANA				
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Timothy Rinkovitch</i>				32. DATE FILED (Month, Day, Year) 11-22-91
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) 00034				
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no. If yes, specify driver, passenger, pedestrian, etc.)		

