#4055 490103 PDG

Chicago Title Insurance Company

2

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA } S. S.
COUNTY OF LAKE

On this 11-29-96 (insert date) before me personally appeared Sara R Fischer

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 Robert A and Sara;
4. Said Robert A Fischer III (fill in name of co-tenant who died) died on 4-16-91 leaving No (insert "a" or "no", if will left, attach a copy) will;
5. The legal description of the premises in question is:

   Lots 48 and 49, Block 3, Resubdivision of Part of Jackson Terrace, hammond, as shown in Plat Book 18, Page 4, in Lake Count, Indiana.

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 Wife

Signature: Sara R Fischer
SARA R Fischer
Address: 2013 Harrison Ave

Subscribed and sworn to before me by the affiant this 29TH day of November, 1996 (insert date)

Mickey L. Hill
Notary Public

My Commission Expires Aug. 23, 1998

This instrument prepared by Sara R. Fischer

96079809

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 DEC -5 PM 2:25
MARGARETTE CLERK RECORDER

FILED
DEC 4 1996
SAM ORLICH
AUDITOR LAKE COUNTY

000251

Local No. 291

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Apr. 17, 1991 — Date Issued

[signature] — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Robert A. Fischer III
2. SEX: Male
3a. TIME OF DEATH: 7:44 a.m.
3b. DATE OF DEATH (Month, Day, Year): April 16, 1991
4. SOCIAL SECURITY NUMBER: 304-32-7668
5a. AGE—Last Birthday (Years): 57
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): Aug. 11, 1933
7. BIRTHPLACE (City and State or Foreign Country): Princeton, IN
8a. WAS DECEDENT A U.S. VETERAN? Yes
8b. YEAR LAST SERVED IN US ARMED FORCES? 1957
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): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Sara Willing
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Custodian
12b. KIND OF BUSINESS/INDUSTRY: Church
13a. RESIDENCE—STATE: IN
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 7013 Harrison Ave.
13e. ZIP CODE: 46324
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): Robert A. Fischer, Jr.
19. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Smith

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Sara Fischer
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7013 Harrison Hammond, IN 46324
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify) [ ] Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): April 18, 1991 St. Joseph Cemetery
21c. LOCATION—City or Town, State: Hammond, IN
22a. EMBALMER'S NAME: James Porras
22b. EMBALMER'S LICENSE NO.: 1045964
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): 1045184
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3002819 5840 Hohman Hammond, IN 46320

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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. Gastrointestinal Bleeding
DUE TO (OR AS A CONSEQUENCE OF):
b. Esophageal Varices
DUE TO (OR AS A CONSEQUENCE OF):
c. Cirrhosis
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 resulting in the underlying cause given 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): No

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) 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: [signature]
29c. MEDICAL LICENSE NO.: 35923
29d. DATE SIGNED (Month, Day, Year): April 17, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): J. Cahan, M.D. 7905 Calumet Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Espinoza M.D.
32. DATE FILED (Month, Day, Year): APR. 18 1991

CORONER USE ONLY

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.

Copy

SBH 06 004 State Form 10110 (R2/3-89)