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FILED

TICOR TITLE INSURANCE

97035565

JUN 03 1997

SAM ORLICH
AUDITOR LAKE COUNTY

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 JUN -3 AM 9:59
MORRIS W. CARTER
RECORDER

GAIL DUNNING, being first duly sworn upon oath, deposes and says:

1. That DR. PRESTON M. DUNNING died on NOVEMBER 18, 19 95 at COMMUNITY HOSPITAL.

2. That BARBARA DUNNING and PRESTON M. DUNNING were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 3 IN BRANTWOOD 5TH ADDITION TO HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 29, PAGE 5, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY.

Key# 27-205-3

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3. That the marital relationship which existed between them at the time they acquired ~~title~~ to said real estate remained in effect and unbroken until the date of (his) ~~(her)~~ death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Gail Dunning
GAIL DUNNING

Subscribed and sworn to before me, a Notary Public, this 28th day of MAY, 19 97.

Kit C Williams
Notary Public

My Commission expires:
12/14/00

County of Residence:
Eagle

000111

This Instrument prepared by GAIL DUNNING

Kit C. Williams
My Commission Expires
December 14, 2000

Ticor Hw. 209909

W
CP

* ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2641-95 State No. ....

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): Dr. Preston M. Dunning
2 SEX: Male
3a TIME OF DEATH: 10:45PM
3b DATE OF DEATH (Month Day Yr): November 18,1995
4 SOCIAL SECURITY NUMBER: 117-07-9204
5a AGE—Last Birthday (Years): 76
5b UNDER 1 YEAR Months Days
5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo. Day Yr): July 20, 1919
7 BIRTHPLACE (City and State or Foreign Country): Plainfield,NJ
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 [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b FACILITY NAME (If not institution, give street and number): 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): Barbara Temyer
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Medical Doctor
12b KIND OF BUSINESS/INDUSTRY: Inland Steel
13a RESIDENCE—STATE: IN
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: Highland
13d STREET AND NUMBER: 8831 Parkway Dr.
13e ZIP CODE: 46322
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+): 5+

PARENTS

18 FATHER'S NAME (First Middle Last): Preston Dunning
19 MOTHER'S NAME (First Middle Maiden Surname): Henrietta J. Winn

INFORMANT

20a INFORMANT'S NAME (Type/Print): Barbara Preston
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8831 Parkway Dr. Highland,IN 46322
20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Removal from State [ ] Entombment [ ] Donation [ ] Other (Specify)
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 24,1995 Richland Cemetery
21c LOCATION—City or Town, State: Windber,PA
22a EMBALMER'S NAME: Brian T. Burns
22b EMBALMER'S LICENSE NO.: 8601763
23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b LICENSE NUMBER (of Licensee): 1021590
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN 46321

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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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Ruptured Thoracic — Approximate Interval Between Onset and Death: 30 min

DUE TO (OR AS A CONSEQUENCE OF): b. Aortic Aneurysm

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 contributing to death but not resulting in the underlying cause given in Part I: Coronary Artery Disease

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 JUN 03 1997
SAM ORLICH
AUDITOR LAKE COUNTY

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT
NOV 21 1995
[signature] LAKE COUNTY HEALTH COMMISSIONER

RECORDER'S OFFICE SEAL INDIANA

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.: 01015522
29d DATE SIGNED (Month Day Year): November 21,1995
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Lowell Steen, M.D. 3641 Ridge Road HIghland,IN 46322

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature]
32 DATE FILED (Month Day Year): November 21,1995

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