97079794

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 NOV 20 AM 11:30
MORRIS W. CARTER
RECORDER

FILED
NOV 19 1997
SAM ORLICH
AUDITOR LAKE COUNTY

2

SURVIVORSHIP AFFIDAVIT

LAWYERS TITLE INS. CORP.
ONE PROFESSIONAL CENTER
SUITE 215
CROWN POINT, IN 46307

Crown Point, INDIANA
(City)

63703

STATE OF INDIANA, COUNTY OF LAKE, SS:

Lois Billen, being first duly sworn, on oath states that she is of lawful age and resides in the County of LAKE, State of Indiana. That she is the surviving spouse of Peter Billen who died on the 26 day of July, 1997, and that as such surviving spouse, is the owner of the following real estate located in LAKE County, Indiana:

Lots 20, 21 and 22, Block 13, Unit 7 of Woodmar, as shown in Plat Book 16, page 34, Lake County, Indiana, and 15 feet of the vacated alley as it adjoins on the West.

That all debts, funeral expenses and doctor bills of said decedent have been fully paid and satisfied, and that said decedent's estate has not been and is not to be administered upon.

That the decedent and this affiant were husband and wife at the time they took title to the above described real estate and that they remained such continuously until the death of said decedent.

11/14/97
Date

Lois Billen
Lois Billen Affiant

Before me, Lori L. Shelby, a Notary Public in and for said County, personally appeared Lois Billen this 14th day of November, 1997 and acknowledged the foregoing document to be his/her voluntary act and deed.

Lori L. Shelby
Lori L. Shelby Notary Public

My commission expires: 11/11/99
Resident of Porter County

This document prepared by: Lois Billen

001208

5+2

* 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

Local No. 1542-97

CERTIFICATE OF DEATH

State No.

20072

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
Peter Nickolas Billen	Male	1:30PM	July 25, 1997

4. SOCIAL SECURITY NUMBER	5a. AGE - Last Birthday (Years)	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr)	7. BIRTHPLACE (City and State or Foreign Country)
317-14-8127	73			Mar 2, 1924	East Chicago, IN 46312

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1945	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Residence [ ] Other (Specify)

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
Community Hospital	Munster	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS INDUSTRY
Married	Lois Herod	Pipefitter	Construction

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Hammond	7338 Magoun Avenue

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16. RACE - American Indian Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46323	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+)

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Stephen Billen	Rose Koronovich

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Lois Billen	7338 Magoun Avenue, Hammond, IN 46324	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	21c. LOCATION - City or Town State
[ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	Jul 30, 1997 Oakland Memory Lanes Crematory	Dolton, IL

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James W. Gholston	1004194	[ ] No [ ] Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1045362	3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

CAUSE OF DEATH

26. PART I. COMPLETE COPY IN THE CENTRAL OFFICE AT INDIANAPOLIS AND DEATH OFFICE WITHIN THE LAKE COUNTY HEALTH DEPT. Enter only one cause on each line. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac Arrhythmia — Minutes
DUE TO (OR AS A CONSEQUENCE OF): JUL 28 1997 Coronary Artery disease — Years
DUE TO (OR AS A CONSEQUENCE OF):
Conditions if any which gave rise to the immediate cause stating the underlying cause last: Alexander S. Kiliane, M.D. LAKE COUNTY HEALTH COMMISSIONER
DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.
Chronic Obstructive Pulmonary disease Leukemia Asbestosis

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or (no))	28a. WAS AN AUTOPSY PERFORMED? (Yes or (no))	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
H Allan Jones DO	02000640	7/28/97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): 9128 Columbia Ave Munster IND 46321

31. HEALTH OFFICER'S SIGNATURE: [signature] M.D.

32. DATE FILED (Month Day Year): July 27, 1997

33. MANNER OF DEATH	34a. DATE OF INJURY (Month Day Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
[X] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide			No	

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.
	No