

2

FILED

STATE OF INDIANA
LAKE COUNTY
FILE NOV 27 1997

97 056 2 11:10:54
SAM ORLICH
AUDITOR LAKE COUNTY

97082152

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT

Donna F. Trimmer, the daughter and surviving joint tenant of Vivian A. Schank, being first duly sworn upon her oath, deposes and says that Vivian A. Schank died on September 6, 1996. Donna F. Trimmer was the surviving joint tenant of Vivian A. Schank, deceased. By virtue of the fact that Donna F. Trimmer was the surviving joint tenant of Vivian A. Schank, deceased, she was the owner of the following described real estate:

LOT 5 IN BLOCK 7 IN HYDE PARK ADDITION TO HAMMOND, AS PER PLAT THEREOF RECORDED SEPTEMBER 10, 1914, IN PLAT BOOK 12, PAGE 3, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

Commonly known as 6324 Jackson Avenue, Hammond, IN 46324
Tax Key No.: 34-159-5

Mail tax bills to:

The estate of Vivian A. Schank was not subject to federal estate tax. Indiana Inheritance tax has yet to be determined and paid.

Dated this 7 day of NOVEMBER, 1997.

Donna F. Trimmer
DONNA F. TRIMMER

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, personally appeared DONNA F. TRIMMER, who acknowledged the execution of the foregoing Affidavit, and delivered said instrument as her free and voluntary act, for the uses and purposes set forth therein.

WITNESS my hand and Notarial Seal this 7 day of November, 1997.

My Commission Expires:
7-22-99

Margaret Royce Galvin
NOTARY PUBLIC

Resident of LAKE
County, Indiana

MARGARET ROYCE GALVIN
Notary's Printed Signature

This document prepared by: MARGARET ROYCE GALVIN, Attorney at Law, 5253 Hohman Avenue, Hammond, Indiana 46320 (219) 933-4715

COMMUNITY TITLE COMPANY
FILE NO 2 14227

001535

11:00
3190

* 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

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

Sept. 9, 1996 *Franklin D. ...*
St. Date Issued *Hammond Health Commissioner*

Local No. 713

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Vivian A. Schank		2 SEX Female	3a TIME OF DEATH 4:13 p.m.	3b DATE OF DEATH (Month Day Yr.) September 6, 1996
4 SOCIAL SECURITY NUMBER 317-32-6499	5a AGE—Last Birthday (Years) 84	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr.) November 17, 1911
7 BIRTHPLACE (City and State or Foreign Country) Vincennes, IN	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? None		8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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. Margaret Mercy - North Campus		9b CITY, TOWN OR LOCATION OF DEATH Hammond	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife give maiden name) None	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Housewife		12b KIND OF BUSINESS/INDUSTRY Own Home
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6324 Jackson Ave.,
13e ZIP CODE 46324	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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, Black, White, etc. (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) Walter Rockaway		
19 MOTHER'S NAME (First Middle, Maiden Surname) Grace Savage		20a INFORMANT'S NAME (Type/Print) Donna Trimmer		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7340 Carolina Ave., Hammond, IN 46323		20c Relationship Daughter		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) September 9, 1996 Elmwood Cemetery		21c LOCATION—City or Town, State Hammond, IN
22a EMBALMER'S NAME Henry J. Blake		22b EMBALMER'S LICENSE NO. FD01019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Eden B. ...</i>		24b LICENSE NUMBER (of Licensee) FD01000857		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LaHayne F.H.—Dalton Chapel FH19400005 6955 Southeastern Ave., Hammond, IN 46323
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 <u><i>Sepsis</i></u> DUE TO (OR AS A CONSEQUENCE OF)		FILED <u><i>5 days</i></u>
Conditions if any which gave rise to the immediate cause stating the underlying cause last		b <u><i>Mesenteric thrombosis</i></u> DUE TO (OR AS A CONSEQUENCE OF)		<u><i>5 days</i></u>
c _____ DUE TO (OR AS A CONSEQUENCE OF)		NOV 24 1997		
d _____ DUE TO (OR AS A CONSEQUENCE OF)				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
27 WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) NO		28 WAS AN AUTOPSY PERFORMED PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO		29 WERE AUTOPSY FINDINGS CONSISTENT WITH CAUSE OF DEATH? (Yes or no) NO
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>Charles ...</i>		29c MEDICAL LICENSE NO. 22651	29d DATE SIGNED (Month, Day, Year) Sept. 9/7/96	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) C. Helms M.D. 9108 Columbia Avenue, Munster, Indiana 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. ...</i>			32 DATE FILED (Month, Day, Year) SEP 09 1996	
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 001536
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.		