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ADDRESS: 5606 Homerlee, East Chicago, IN

97088740

FILED

DEC 23 1997

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

97 DEC 23 AM 11:36

MORRISON CENTER

SURVIVORSHIP AFFIDAVIT

On this 5th day of December, 1997, before me personally appeared ANNA M. DEWITT, who being duly sworn upon her oath, did say that:

1. Affiant resides at 5606 Homerlee, East Chicago, IN 46312

2. Affiant is the adult spouse of JEWELL LEE DEWITT, deceased, and is the owner of the premises located at 5606 Homerlee, East Chicago, Indiana, and described as follows:

> Lot 2, except the North 24 feet thereof, and the North 24 feet of Lot 3 in Block 1, in Roxanna Park 4th Addition to East Chicago, as per plat thereof, recorded in Plat book 29, Page 47, in the Office of the Recorder of Lake County, Indiana.

3. Said premises were formerly owned as tenants by the entireties, by JEWELL LEE DEWITT AND ANNA M. DEWITT, husband and wife.

4. Said JEWELL LEE DEWITT died on October 4, 1997, leaving no will. A certified copy of the death certificate of JEWELL LEE DEWITT is attached hereto as "Exhibit A".

5. That to the best of Affiant's knowledge, there is no estate of inheritance tax liability by reason of the death of JEWELL LEE DEWITT; and all funeral expenses of last illness have been paid in full.

001491

13.00
14600 Su

6. Said JEWELL LEE DEWITT and ANNA M. DEWITT were never divorced, and Affiant is the surviving spouse of said decedent.

Anna M. DeWitt
ANNA M. DEWITT

SUBSCRIBED and SWORN to before me, by the Affiant, on this 5 day of DECEMBER, 1997.

Judith A. Osinski
JUDITH A. OSINSKI, Notary Public

My Commission Expires:
3/20/00

Resident of Lake County

THIS INSTRUMENT PREPARED BY:
THOMAS L. KIRSCH, Attorney at Law
131 Ridge Road, Munster, In 46321
(219) 836-1384

* 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

Local No. 239

CERTIFICATE OF DEATH

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): Jewell Lee DeWitt

2 SEX: Male

3a TIME OF DEATH: 5:30 P M

3b DATE OF DEATH (Month, Day, Yr): October 4, 1997

4 *SOCIAL SECURITY NUMBER: 316-24-8935

5a AGE—Last Birthday (Years): 68

5b UNDER 1 YEAR (Months, Days):

5c UNDER 1 DAY (Hours, Minutes):

6 DATE OF BIRTH (Mo, Day, Yr): November 6, 1928

7 BIRTHPLACE (City and State or Foreign Country): Bedford, IN

8a WAS DECEDENT A U.S. VETERAN? Yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1953

8c 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. Catherine Hospital

9c CITY, TOWN, OR LOCATION OF DEATH: East Chicago

9d COUNTY OF DEATH: Lake

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Anna M. Moritz

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Computer Engineer

12b KIND OF BUSINESS/INDUSTRY: AMOCO Oil Co.

13a RESIDENCE—STATE: Indiana

13b COUNTY: Lake

13c CITY TOWN OR LOCATION: East Chicago

13d STREET AND NUMBER: 5606 Homerlee Ave.,

13e ZIP CODE: 46312

13f INSIDE CITY LIMITS [ ] No [X] Yes

13g ON A FARM? [X] No [ ] Yes

14 CITIZEN OF WHAT COUNTRY? USA

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): 11; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): Evertt DeWitt

19 MOTHER'S NAME (First, Middle, Maiden Surname): Mary Poole

INFORMANT

20a INFORMANT'S NAME (Type/Print): Anna M. DeWitt

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5606 Homerlee AVe.,East Chicago, IN46312

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: [ ] Entombment [X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 8, 1997 Chapel Lawn Memorial Gardens

21c LOCATION—City or Town, State: Schererville, IN

22a EMBALMER'S NAME: Henry J. Blake

22b EMBALMER'S LICENSE NO: FD01019406

23 WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR: Ellen B Lefayne

24b LICENSE NUMBER (of Licensee): FD01000857

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: LaHayne Funeral Home,Inc., FH19400005 6955 Southeastern Ave.,Hammond,IN46324

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. Approximate Interval Between Onset and Death.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Cerebro Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
b.
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

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PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO

28 WAS AUTOPSY PERFORMED? (Yes or no): NO

29 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: M Krad

29c MEDICAL LICENSE NO.: 00 29360

29d DATE SIGNED (Month, Day, Year): October 6, 1997

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): M. Krad, M.D., 1849 N. Cline Ave., Griffith, IN 46319

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Dr. Timothy Ravkovich

32 DATE FILED (Month, Day, Year): 10-6-97

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 Ooccurred:

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): 001492

34g DATE PRONOUNCED DEAD (Month, Day, Year):

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.