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AFFIDAVIT OF SURVIVORSHIP

JOSEPHINE PONTOW, being first duly sworn upon her oath, states as follows:

1. That she resides at 6323 Rhode Island, Hammond, Indiana.
2. That she and Warren T. Pontow, Sr., also known as Warren T. T. Pontow, were married on February 4, 1950, and they remained married until his death.
3. That she was the wife of Warren T. Pontow, Sr. who died intestate a resident of Lake County, Indiana on September 30, 1992.
4. At the time of the death of Warren T. Pontow, Sr., affiant and he were the owners as tenants by the entireties of the following described real property located in Lake County, Indiana:

All Lot 19, except the South 15 feet thereof, all Lot 20, except North 20 feet thereof, Block 2, Clineway Addition to the City of Hammond, Indiana, as per plat thereof, recorded in Plat Book 20 Page 30 in the office of the Recorder of Lake County, Indiana.

commonly known as 6323 Rhode Island, Hammond, IN, Key No. 32-150-20

5. That all the debts, expenses of the last illness, funeral expenses, and inheritance tax, if any, resulting from the death of Warren T. Pontow, Sr. have been paid and that said estate was not large enough to subject it to a federal estate tax.

Further affiant saith not.



Josephine Pontow
Josephine Pontow

STATE OF INDIANA, COUNTY OF LAKE, SS:

Before me the undersigned, a Notary Public for said county and state, personally appeared **Josephine Pontow**, and being first duly sworn upon her oath, states that the facts set forth in the foregoing instrument are true. Signed and sealed this 12th day of April, 1998.

Ruth H. Bramer
Ruth H. Bramer, Notary Public

My Commission Expires: 1/12/2008
County of Residence of Notary: Lake

FILED

This instrument prepared by:

Edward P. Grimmer, Attorney at Law, 603 North Main Street, Crown Point, IN 46307-3233

SAM ORLICH
AUDITOR LAKE COUNTY

APR 17 1998

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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

**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.

Local No. 850

S. Oct 1, 1992
Date Issued Hammond Health Commission

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER
USE ONLY

1 DECEASED—NAME (First, Middle, Last) Warren T. Pontow, Sr.		2 SEX Male		3a TIME OF DEATH 11:20 AM		3b DATE OF DEATH (Month, Day, Year) September 30, 1992	
4 SOCIAL SECURITY NUMBER 355-18-2744		5a AGE—Last Birthday (Years) 64		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) Aug. 10, 1928		7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois					
8a WAS DECEDENT A U.S. VETERAN? YES		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954		8c PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) 6323 Rhode Island			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) Josephine Ernie		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Truck Driver		12b KIND OF BUSINESS/INDUSTRY Transport Co.	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Hammond		13d STREET AND NUMBER 6323 Rhode Island	
13e ZIP CODE 46320		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)					
18 FATHER'S NAME (First, Middle, Last) Warren Pontow				19 MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Rottmann			
20a INFORMANT'S NAME (Type/Print) Josephine Pontow			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6323 Rhode Island Hammond, Indiana			20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) October 3, 1992 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana			
22a EMBALMER'S NAME Raymond White		22b EMBALMER'S LICENSE NO. FDO 8700086		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>A. Kuiper</i>		24b LICENSE NUMBER (of Licensee) FDO 1014511		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500			
26 PART I Enter the disease, 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. Adenocarcinoma of the stomach and lower esophagus							
b. _____							
c. _____							
d. _____							
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) N/A		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			
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>Salman Gulicum</i>						29c MEDICAL LICENSE NO. 27970	
29d DATE SIGNED (Month, Day, Year) Oct. 10/1/92							
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 9116 Columbia Ave. Munster, IN 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Dr. Alan J. J. ...</i>						32 DATE FILED (Month, Day, Year) October 1, 1992	
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		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.			