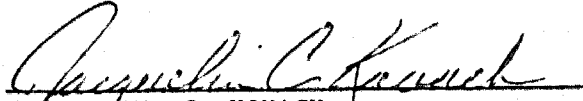


7. That JOHN J. DILLON and MARIE A. DILLON were never divorced, and this Affidavit is made for the purpose of clearing title to said property to MARIE A. DILLON, surviving tenant by the entireties.


JACQUELINE C. KOVACH

SUBSCRIBED and SWORN to before me, by the Affiant, on this 11th day of June, 1998.



JUDITH A. OSINSKI, Notary Public

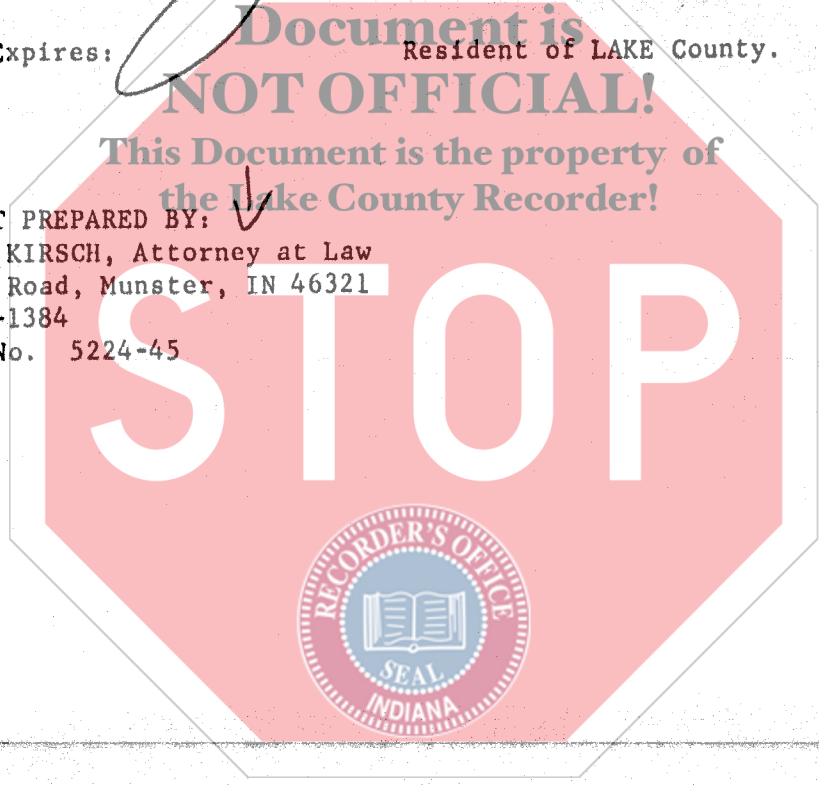
My Commission Expires:
3/20/00

Resident of LAKE County.

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THIS INSTRUMENT PREPARED BY: 
THOMAS L. KIRSCH, Attorney at Law
131 Ridge Road, Munster, IN 46321
(219) 836-1384
Attorney No. 5224-45



PLAINLY WITH UNFADING INK THIS IS A PERMANENT RECORD

Form for State Office Use

INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

State No. _____

Local No. 352-87

001271

FUNERAL HOME
 No. 729
 FUNERAL DIRECTOR'S LICENSE No. 104
 FUNERAL DIRECTOR'S LICENSE No. 865
 EMBALMER'S NAME Thos. Owens
 EMBALMER'S LICENSE No. 104
 FUNERAL DIRECTOR'S LICENSE No. 865
 EMBALMER'S SIGNATURE Thos. Owens

TYPE OR PRINT IN PERMANENT INK FOR INSTRUCTIONS SEE HANDBOOK

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCY BEFORE ADMISSION

PARENTS

DISPOSITION

M.D. OR D.O.

CONDITION OF BODY AT EXAMINATION AND RESULTS OF EXAMINATION

DECLARED—NAME John J. Dillon		SEX M	DATE OF DEATH 2-6-87
RACE WHITE	AGE—Last Birthday 80	DATE OF BIRTH 4-20-06	COUNTY OF DEATH LAKE
CITY, TOWN OR LOCATION OF DEATH MUNSTER		HOSPITAL OR OTHER INSTITUTION COMMUNITY HOSP.	IF HOSP. OR INST. GIVE NAME AND NO. OF STATE REG. HOSPITAL
STATE OF BIRTH IN.	COUNTRY OF BIRTH U.S.A.	MARRIED NEVER MARRIED MARRIED	SUPPORTING SPOUSE MARIE
SOCIAL SECURITY NUMBER 306-01-7843	USUAL OCCUPATION MANAGEMENT	KIND OF BUSINESS OR INDUSTRY ARCO OIL CO.	
RESIDENCE—STATE IN.	COUNTY LK.	CITY, TOWN OR LOCALITY WHITING	ZIP CODE 46394
STREET AND NUMBER 1729 CLEVELAND AV.	APARTMENT OR BOX NUMBER	APARTMENT OR BOX NUMBER	PHONE ON A FARM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IS DECEASED OF SPANISH DESCENT? IF YES SPECIFY MEXICAN CUBAN PUERTO RICAN <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		INDICATE CITY LIMITS SPECIFY COUNTY	
FATHER—NAME Michael	MOTHER—NAME Mary Allen		
DECEASED—NAME Marie	RELATIONSHIP wife	MAILING ADDRESS 1729 Cleveland Whiting In. 46394	
BURIAL, CREMATION, REMOVAL, OTHER burial	CENETERY OR CREMATORY—FUNERAL HOME CALVARY CEM.	LOCATION PORTAGE, IN.	
DATE 2/9/87	FUNERAL HOME—NAME AND ADDRESS OWENS FUNERAL HOME 16-119th St. Whiting, In. 46394		
Signature <i>Dr. C. C. ...</i>	DATE SIGNED 4/23/87	HOUR OF DEATH	
NAME OF ATTENDING PHYSICIAN FRED ADLER M.D.			
MAILING ADDRESS 843 Jay Ct. Blue Bell Pa 19004			
HEALTH OFFICER—Signature <i>Charles Johnson</i>		DATE RECEIVED LOCAL HEALTH OFFICER 2-23-87	
IMMEDIATE CAUSE Cerebral vascular accident		DAYS ELAPSED SINCE ONSET OF ILLNESS 5 days	
PARTIAL CAUSE Metabolic acidosis		DAYS ELAPSED SINCE ONSET OF ILLNESS 4 days	
OTHER CAUSE —		DAYS ELAPSED SINCE ONSET OF ILLNESS 6-5-1980	

DOCUMENT NOT OFFICIAL
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SAM GRILICH
 CLERK
 CLERK OF SUPERIOR COURT
 SUPERIOR COURT
 LAKE COUNTY, INDIANA

Alvin ...
 JUDGE OF THE COURT

* 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

State No.

Local No. 0442-98

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) MARIE A. DILLON		2 SEX FEMALE	3a TIME OF DEATH 1:10 A.M.	3b DATE OF DEATH (Month, Day, Yr.) FEBRUARY 18, 1998	
4 SOCIAL SECURITY NUMBER 308-44-3192	5a AGE—Last Birthday (Years) 88	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) November 20, 1909	
7 BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA	8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a 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		
9b FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9c CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) widowed	11 SURVIVING SPOUSE (If wife, give maiden name) N/A	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker	12b KIND OF BUSINESS/INDUSTRY own home		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN, OR LOCATION WHITING	13d STREET AND NUMBER 1729 Cleveland Avenue		
13e ZIP CODE 46394	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input 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) 10		17a Elementary/Secondary (0-12) 10			
17b College (1-4 or 5+)					
18 FATHER'S NAME (First, Middle, Last) John Valovcin		18 MOTHER'S NAME (First, Middle, Maiden Surname) Ann Buchanin			
20a INFORMANT'S NAME (Type/Print) Leatha Dillon		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1836 So. River Dr., Munster, IN 46321		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) February 21, 1998 Calvary Cemetery		21c LOCATION—City or Town, State Portage, Indiana	
22a EMBALMER'S NAME THOS. OWENS		22b EMBALMER'S LICENSE NO. FDE 1001049	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thos Owens</i>		24b LICENSE NUMBER (of Licensee) FDE1001049	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME OWENS FUNERAL HOME FDH3007291 816-119th St., Whiting, IN 46394		
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. SEPSIS URINARY TRACT INFECTION FEB 24, 1998				Approximate Interval Between Onset and Death DAYS	
26 PART II Other significant conditions, conditions contributing to death but not previously stated in Part I. Renal Failure					
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)	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, date, time, 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>Michael Kemp M.D. Attending</i>		29c MEDICAL LICENSE NO. 01047261	29d DATE SIGNED (Month, Day, Year) FEBRUARY 20, 1998		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) SAM ORLICH MICHAEL KEMP, M.D. 2450 169TH STREET HAMMOND, INDIANA 46323					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams M.D.</i>			32 DATE FILED (Month, Day, Year) February 24, 1998		
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.			

001272

c