

7



TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

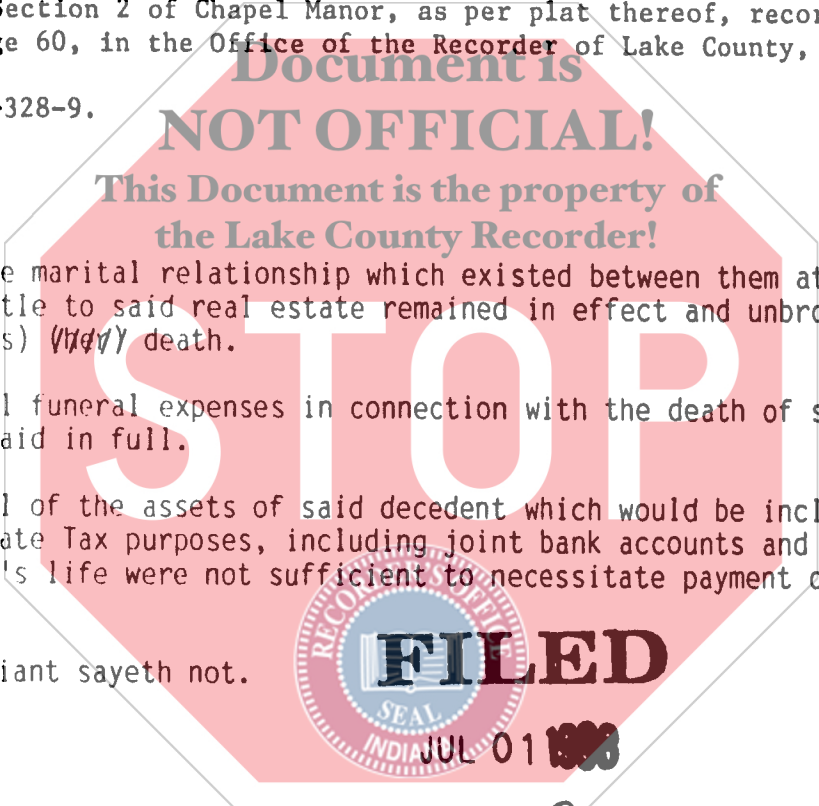
Beverly J. Spillmeier, being first duly sworn upon oath, deposes and says:

1. That Victor L. Spillmeier died on August 17, 1997 at 8040 Chapel Dr., Merrillville, .IN

2. That Victor L. Spillmeier and Beverly J. Spillmeier were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 25 in Section 2 of Chapel Manor, as per plat thereof, recorded in Plat Book 33 page 60, in the Office of the Recorder of Lake County, Indiana.

Key No. 15-328-9.



3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) ~~Victor's~~ death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Beverly J. Spillmeier
AUDITOR LAKE COUNTY, IN

Subscribed and sworn to before me, a Notary Public, this 29th day of June, 1998.

Linda J. McBride
Linda J. McBride Notary Public

My Commission expires:

1-26-99

County of Residence:

Lake

This Instrument prepared by Beverly J. Spillmeier

1100
KRM
11

* 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. ... 740-97

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

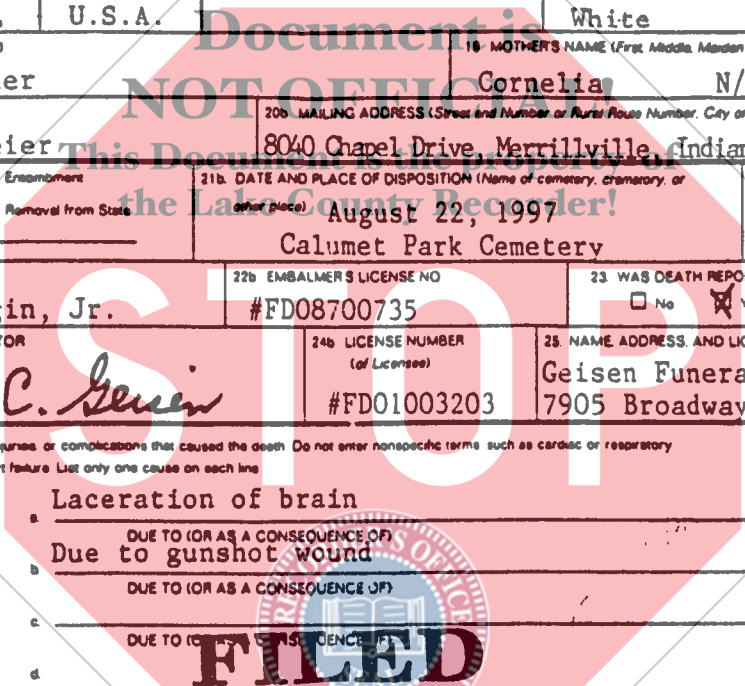
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Victor L Spillmeier		2. SEX Male	3a. TIME OF DEATH 7:50P M	3b. DATE OF DEATH (Month, Day, Yr) August 17, 1997	
4. SOCIAL SECURITY NUMBER 308-22-3028	5a. AGE—Last Birthday (Years) 69	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Yr) October 26, 1927	
7. BIRTHPLACE (City and State or Foreign Country) Jasper, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9a. FACILITY NAME (If not institution, give street and number) 8040 Chapel Drive		9b. CITY/TOWN OR LOCATION OF DEATH Merrillville	9c. COUNTY OF DEATH Indiana		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Beverly Wyro	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Engineer	12b. KIND OF BUSINESS/INDUSTRY Standard Oil		
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY/TOWN OR LOCATION Merrillville	13d. STREET AND NUMBER 8040 Chapel Drive		
13e. ZIP CODE 46410	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <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. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		18. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5 +)			
18. FATHER'S NAME (First, Middle, Last) Victor Spillmeier		19. MOTHER'S NAME (First, Middle, Maiden Surname) Cornelia N/A			
20a. INFORMANT'S NAME (Type/Print) Beverly Spillmeier		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8040 Chapel Drive, Merrillville, Indiana 46410	20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" 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) August 22, 1997 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville, Indiana	
22a. EMBALMER'S NAME Robert A. Craig, Jr.		22b. EMBALMER'S LICENSE NO. #FD08700735	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>William C. Geisen</i>		24b. LICENSE NUMBER (of Licensee) #FD01003203	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410		
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) Laceration of brain a. Due to (IGR) AS A CONSEQUENCE OF Due to gunshot wound b. Due to (IGR) AS A CONSEQUENCE OF c. Due to (IGR) AS A CONSEQUENCE OF d.				Approximate Interval Between Onset and Death Unknown	
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		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge and belief, I certify that the information furnished on this certificate is true and correct to the best of my knowledge and belief, and that I am a duly licensed physician at the time, date, and place and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of my personal or professional knowledge, I certify that the information furnished on this certificate is true and correct to the best of my knowledge and belief, and that I am a duly licensed health officer at the time, date, and place and due to the cause(s) as stated. <input checked="" 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. Deputy					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Saul Blasto</i>		29c. MEDICAL LICENSE NO. N/A	29d. DATE SIGNED (Month, Day, Year) August 21, 1997		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Paul R. Castro, Deputy Coroner, 793 North Main Street, Crown Point, Indiana 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Alexander P. ... MD</i>				32. DATE FILED (Month, Day, Year) August 21, 1997	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) Aug 17, 1997	34b. TIME OF INJURY Unknown	34c. INJURY AT WORK? (Yes or no) No	34d. DESCRIBE HOW INJURY OCCURRED Gunshot wound
34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) Residence		34b. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8040 Chapel Drive Merrillville, Indiana			
34g. DATE PRONOUNCED DEAD (Month, Day, Year) August 17, 1997		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. No			



000013