

3

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

Chicago Title Insurance Company

99087743

Chicago Title Insurance Company  
99 OCT 26 AM 9:49

H-19904889 LD

MORRIS W. CARTER  
SURVIVORSHIP AFFIDAVIT  
RECORDER

On this 27th day of Aug, 1999, before me personally appeared  
(insert date) Edward Adler

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is Oliver  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Edward Adler and Dorothy Adler;
4. Said Dorothy Adler  
(fill in name of co-tenant who died)  
died on December 10, 1997  
leaving NO will;  
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:  
The East 30 feet of Lot 56 and the West 30 feet of Lot 57 in Suburban Terrace Addition to the Town of Dyer, as per Plat thereof, recorded in Plat Book 31, page 99 in the Office of the Recorder of Lake County, INDIANA
6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent?  Yes  No  
If yes, then estimated taxes due are \$ 0-  
The taxes due are  paid or  unpaid.

FILED

OCT 25 1999

PETER BENJAMIN  
LAKE COUNTY AUDITOR

001599 13:00  
pm  
cr

7. Where this affidavit relates to a tenancy by the entirety, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:

8. Affiant's relationship to the deceased was

husband

Signature: [Signature]

Edward Adler

Printed Name

Edward Adler

Address:

513 Coral Drive  
Dyer INDIANA  
46311

Subscribed and sworn to before me by the affiant

this

Edward Adler

(insert date)

[Signature]

Notary Public

Printed Name

Kandall W. Hoyle

My County of Residence is:

Lake

In the State of

INDIANA

My Commission Expires

August 10, 2001

This instrument prepared by

Edward Adler

**FILED**

OCT 25 1999

TOTAL P. 02

PETER BENJAMIN  
LAKE COUNTY AUDITOR

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

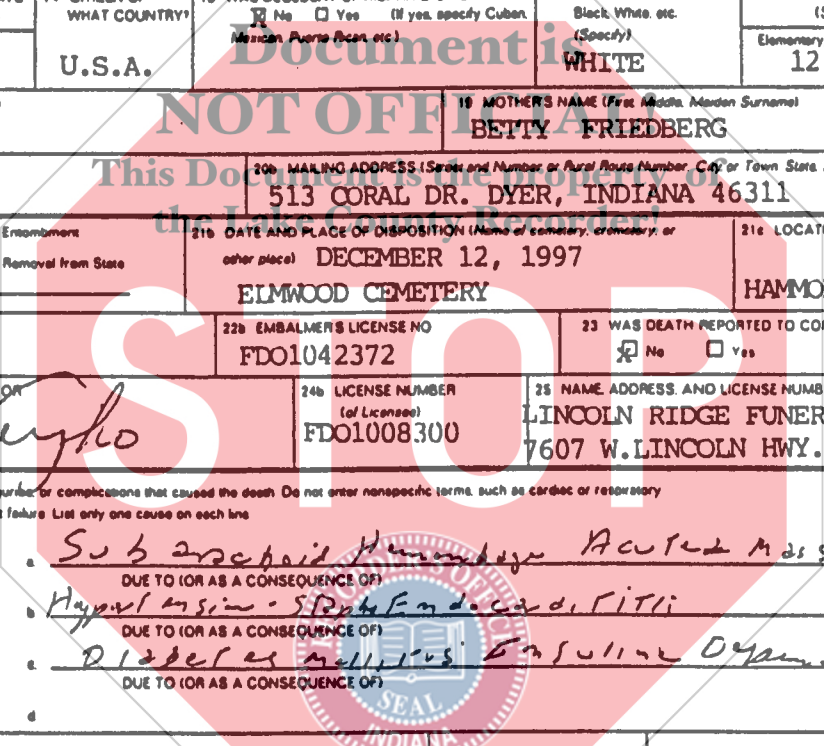
## CERTIFICATE OF DEATH

State No. ....

Local No. 2614-99

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

1 DECEASED—NAME (First Middle Last) <b>DOROTHY ADLER</b>		2 SEX <b>FEMALE</b>	3a TIME OF DEATH <b>5:24 P M</b>	3b DATE OF DEATH (Month Day Year) <b>DECEMBER 10, 1997</b>	
4 SOCIAL SECURITY NUMBER <b>055-26-9861</b>	5a AGE—Last Birthday (Years) <b>64</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) <b>SEPTEMBER 23, 1933</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>NEW YORK</b>	8a PLACE OF DEATH (Check only one See instructions)				
8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>NONE</b>	HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		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) <b>THE COMMUNITY HOSPITAL</b>		9b CITY, TOWN OR LOCATION OF DEATH <b>MUNSTER</b>		9c COUNTY OF DEATH <b>LAKE</b>	
10 MARITAL STATUS (Specify) <b>MARRIED</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>EDWARD ADLER</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HOMEMAKER</b>		12b KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>	
13a RESIDENCE—STATE <b>INDIANA</b>	13b COUNTY <b>LAKE</b>	13c CITY TOWN OR LOCATION <b>DYER</b>		13d STREET AND NUMBER <b>513 CORAL DR.</b>	
13e ZIP CODE <b>46311</b>	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? <b>U.S.A.</b>	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) <b>WHITE</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed)				17 Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
18 FATHER'S NAME (First Middle Last) <b>AL SCHLES</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>BETTY FRIEDBERG</b>			
20a INFORMANT'S NAME (Type/Print) <b>EDWARD ADLER</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>513 CORAL DR. DYER, INDIANA 46311</b>		20c Relationship <b>HUSBAND</b>	
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) <b>DECEMBER 12, 1997 ELMWOOD CEMETERY</b>		21c LOCATION—City or Town, State <b>HAMMOND, INDIANA</b>	
22a EMBALMER'S NAME <b>CHARLES WELLS</b>		22b EMBALMER'S LICENSE NO. <b>FDO1042372</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Eli Tuzho</i>		24b LICENSE NUMBER (of Licensee) <b>FDO1008300</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 4631</b>	
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) <b>Subarachnoid Hemorrhage Acute Massive</b> DUE TO (OR AS A CONSEQUENCE OF)					
Conditions if any, which gave rise to the immediate cause, stating the underlying cause last <b>Hypertension - Stage 2 Endocarditis</b> DUE TO (OR AS A CONSEQUENCE OF)					
<b>Diabetes mellitus Insulin Dependent</b> 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 90 DAYS POSTPARTUM? <input checked="" type="checkbox"/> (Yes or no)		28a WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> (Yes or no)		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/>	
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>Alexander S. Williams MD</i>			
29c MEDICAL LICENSE NO. <b>01026158</b>		29d DATE SIGNED (Month Day, Year) <b>DECEMBER 16, 1997</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>ADELA PEREZ, MD 2156 HART ST DYER, INDIANA 46311</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>				32 DATE FILED (Month Day, Year) <b>December 16, 1997</b>	
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 <b>THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT</b>
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34d 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.			



JUN 4 1999

*Alexander S. Williams MD*  
LAKE COUNTY HEALTH COMMISSIONER