

STATE OF INDIANA)
COUNTY OF LAKE)

SS:

2002 095332

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2002 OCT 22 PM 12: 08

MORRIS W. CARTER
RECORDER

2

AFFIDAVIT OF SURVIVORSHIP

Comes now the Affiant, Arlene Kistler, and being duly deposed, upon her oath, states as follows:

1. That Eugene D. Kistler and I were married on the 10th day of March, 1944.
2. That Eugene D. Kistler and I were the owners, as Husband and Wife, of the following described real estate:

Lots Numbered Twenty-nine (29), Thirty (30) and the South Half of Lot No. Twenty-eight (28), in Block No. Eighteen (18), as marked and laid down on the recorded plat of Unit 5, Woodmar, Hammond, Lake County, Indiana, as the same appears of record in Plat Book 17, page 23, in the Recorder's Office of Lake County, Indiana.

Commonly Described As: 7050 Magoun
Hammond, Indiana 46324

3. That died on the 8th day of August 2002, as evidenced by the attached Certificate of Death Certificate.

4. That I am the sole owner the above described property.

FURTHER AFFIANT SAYETH NOT.

Arlene Kistler
ARLENE KISTLER

STATE OF INDIANA)
COUNTY OF LAKE)

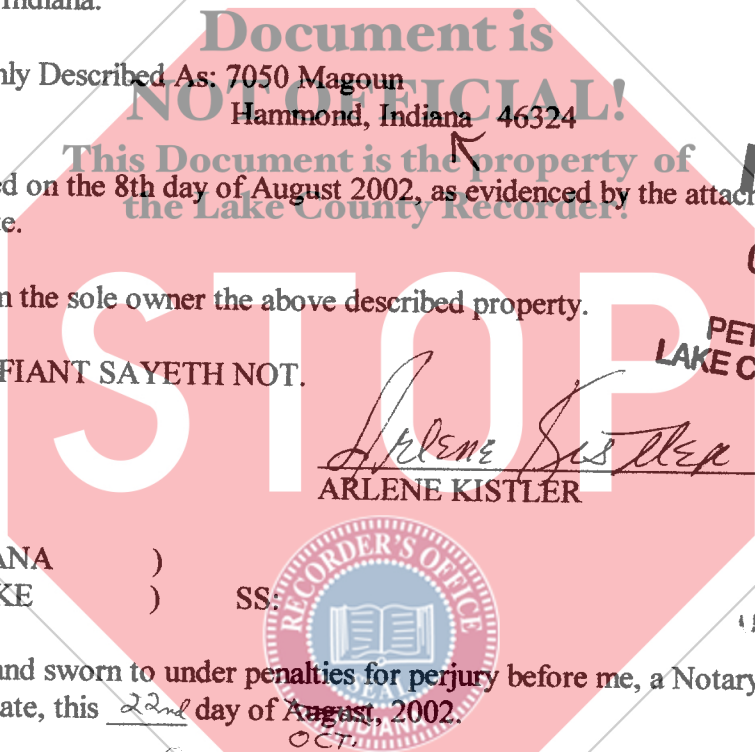
SS:

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Subscribed and sworn to under penalties for perjury before me, a Notary Public in and for said County and State, this 22nd day of August, 2002.

Donald E. Knight
NOTARY PUBLIC

My Commission Expires: 4/1/09



FILED
OCT 22 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

1200 RM

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue 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. 1349-02

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

RENTS

FORMANT

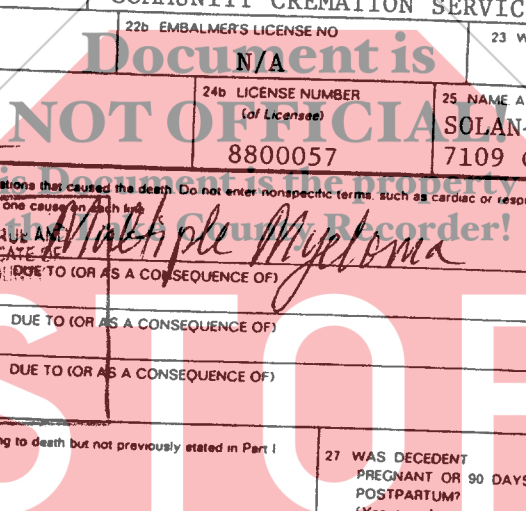
POSITION

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1 DECEASED—NAME (First, Middle, Last) EUGENE D. KISTLER		2 SEX MALE	3a TIME OF DEATH 6:42 P M	3b DATE OF DEATH (Month, Day, Yr.) AUGUST 8, 2002	
4 *SOCIAL SECURITY NUMBER 311-28-1788	5a AGE—Last Birthday (Years) 70	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) SEPTEMBER 29, 1931	
7a WAS DECEDENT A U.S. VETERAN? YES	7b YEAR LAST SERVED IN U.S. ARMED FORCES? 1954	7 BIRTHPLACE (City and State or Foreign Country) KANKAKEE, ILLINOIS			
8a FACILITY NAME (If not institution, give street and number) WILLIAM J. RILEY HOSPICE RESIDENCE		9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) WILLIAM J. RILEY HOSPICE RESIDENCE		9c CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9d COUNTY OF DEATH LAKE		
10. MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) ARLENE DZUROVCAK	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) TRAFFIC CONTROL		12b KIND OF BUSINESS/INDUSTRY HAMMOND POLICE DEP'T.	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN, OR LOCATION HAMMOND		13d STREET AND NUMBER 7050 MAGOUN AVENUE	
13e ZIP CODE 46324	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) 12 College (1-4 or 5+) 2			
18 FATHER'S NAME (First, Middle, Last) CHARLES KISTLER		19 MOTHER'S NAME (First, Middle, Maiden Surname) MARY TAYLOR			
20a INFORMANT'S NAME (Type/Print) ARLENE M. KISTLER		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7050 MAGOUN AVE., HAMMOND, IN. 46324		20c Relationship WIFE	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) AUGUST 13, 2002		21c LOCATION—City or Town, State SCHERERVILLE, INDIANA	
22a EMBALMER'S NAME NONE		22b EMBALMER'S LICENSE NO. N/A		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dean L. Wagner</i>		24b LICENSE NUMBER (of Licensee) 8800057	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN-PRUZIN FUNERAL HOME FH83002893 7109 CALUMET AVE., HAMMOND, IN. 46324		
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF) AUG 1, 2002 CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) Approximate Interval Between Onset and Death 6 weeks					
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) n/a		
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) as stated					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Barbara L. Fuller, M.D.</i>		29c. MEDICAL LICENSE NO. 01034701	29d. DATE SIGNED (Month, Day, Year) OCT 22 2002		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <i>Barbara L. Fuller, M.D. 801 MacArthur Blvd</i>					
31. HEALTH OFFICER'S SIGNATURE <i>Barbara L. Fuller, M.D.</i>					
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) PETER BENJAMIN LAKE COUNTY AUDITOR August 13, 2002			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			



FILED

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