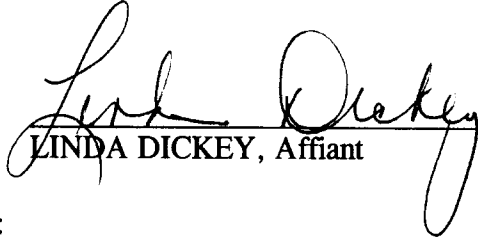




GEORGE M. KRAVICZ JR., DECEASED  
AFFIDAVIT OF SURVIVORSHIP  
PAGE TWO

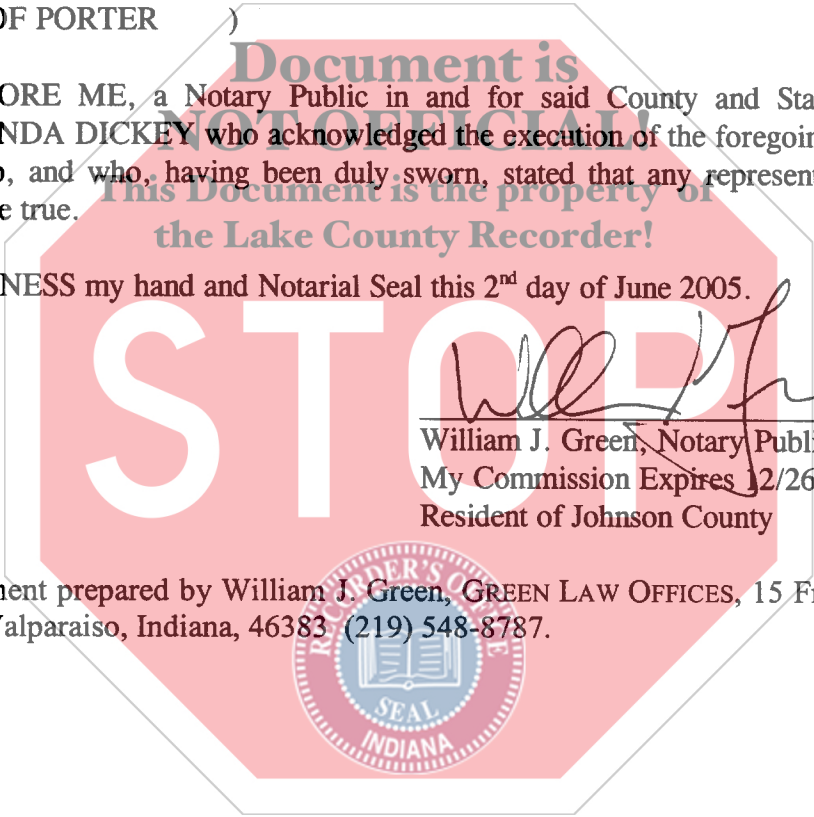
That BERNICE KRAVICZ died on the 21<sup>st</sup> day of July 2004 and her Estate is currently pending in the Circuit Court of Lake County, under **Cause Number 45C01-0408-EU-118**.


  
LINDA DICKEY, Affiant

STATE OF INDIANA     )  
                                  ) SS:  
COUNTY OF PORTER    )

BEFORE ME, a Notary Public in and for said County and State, personally appeared LINDA DICKEY who acknowledged the execution of the foregoing Affidavit of Survivorship, and who, having been duly sworn, stated that any representations therein contained are true.

WITNESS my hand and Notarial Seal this 2<sup>nd</sup> day of June 2005.



  
William J. Green, Notary Public  
My Commission Expires 12/26/2007  
Resident of Johnson County

This instrument prepared by William J. Green, GREEN LAW OFFICES, 15 Franklin Street, Suite 235, Valparaiso, Indiana, 46383 (219) 548-8787.

This document not valid unless stamped on reverse side and embossed with raised seal of Porter County

PORTER COUNTY  
CERTIFICATE OF DEATH

PORTER COUNTY HEALTH DEPARTMENT  
155 Indiana Ave.  
Suite 104  
Valparaiso, IN 46383

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED—NAME (First Middle Last) GEORGE M. KRAVICZ, JR.				2. SEX Male		3a. TIME OF DEATH 11:10PM		3b. DATE OF DEATH (Month Day Yr) October 15, 1999	
4. SOCIAL SECURITY NUMBER 316-22-9204		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) December 8, 1928		7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES 1948		9a. 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) <input type="checkbox"/> Residence					
9b. FACILITY NAME (If not institution, give street and number) Valparaiso Care & Rehab. Ctr.				9c. CITY TOWN OR LOCATION OF DEATH Valparaiso			9d. COUNTY OF DEATH Porter		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Bernice Gerarge		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Machinist			12b. KIND OF BUSINESS INDUSTRY Steel		
13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY TOWN OR LOCATION Gary		13d. STREET AND NUMBER 4101 Miller Avenue			
13e. ZIP CODE 46403	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) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 2	
18. FATHER'S NAME (First, Middle, Last) George Kravicz					19. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Adams				
20a. INFORMANT'S NAME (Type/Print) Bernice Kravicz				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Miller Avenue, Gary, IN 46403				20c. Relationship Wife	
21a. METHOD OF DISPOSITION <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) October 20, 1999 Calvary Crematory			21c. LOCATION - City or Town State Portage, Indiana			
22a. EMBALMER'S NAME James J. Krause			22b. EMBALMER'S LICENSE NO. FDO1006463		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>			24b. LICENSE NUMBER (of Licensee) FDO1006463		25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Rees Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342				
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)  Conditions if any which gave rise to the immediate cause stating the underlying cause last  a. <u>Respiratory</u> DUE TO (OR AS A CONSEQUENCE OF)  b. _____ DUE TO (OR AS A CONSEQUENCE OF)  c. _____ DUE TO (OR AS A CONSEQUENCE OF)  d. _____								Approximate interval Between Onset and Death  <u>Yes</u>	
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) 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>Kenneth A. Black</i>				29c. MEDICAL LICENSE NO 24841		29d. DATE SIGNED (Month Day Year) 10/18/99		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (JEM 26) (Type/Print) Kenneth A. Black MD/ Portage Community Hospital, 3630 Willowcreek Road, 1st Fl, Portage, IN 46368									
31. HEALTH OFFICER'S SIGNATURE <i>Gary A. Sabulka MD</i>							32. DATE FILED (Month Day Year) October 18, 1999		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.						