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STATE OF INDIANA)

COUNTY OF LAKE)

2008 062781

AFFIDAVIT OF SURVIVORSHIP

I, Robert K. Szillage, Jr., Personal Representative of the Unsupervised Estate of Doris L. Szillage, being duly sworn, do depose and say as follows:

1. That I am the duly appointed Personal Representative of the Unsupervised Estate of Doris L. Szillage, who died on April 3, 2006, pending in the Lake Circuit Court under Cause Number 45C01-0606-EU-00098.

2. That the decedent, Doris L. Szillage and Robert K. Szillage, deceased, were Husband and Wife at the time of his death, December 2, 2005.

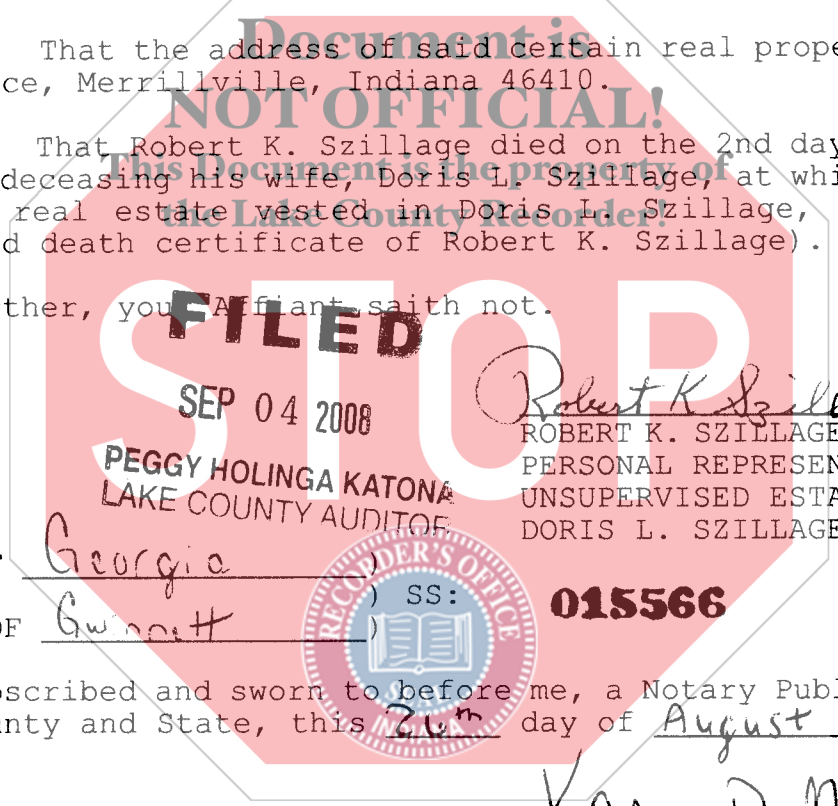
4. That the decedents, Doris Szillage and Robert K. Szillage, at the time of his death, owned certain real property as Husband and Wife, tenants by entireties; and

5. That the address of said certain real property is 524 W. 66th Place, Merrillville, Indiana 46410.

6. That Robert K. Szillage died on the 2nd day of December, 2005 predeceasing his wife, Doris L. Szillage, at which time title to said real estate vested in Doris L. Szillage, (see attached certified death certificate of Robert K. Szillage).

Further, you Affiant saith not.

45-12-09-905-623,000-030



SEP 04 2008

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

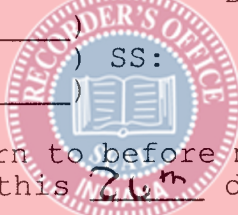
Robert K Szillage Jr.
ROBERT K. SZILLAGE, JR., AFFIANT
PERSONAL REPRESENTATIVE OF THE
UNSUPERVISED ESTATE OF
DORIS L. SZILLAGE, DECEASED

STATE OF

Georgia

COUNTY OF

Gwinnett



SS:

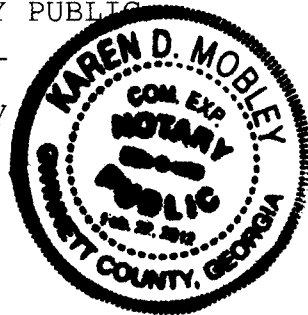
015566

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 20th day of August, 2008.

Karen D. Mobley
NOTARY PUBLIC

My Commission Expires: 2/22/2012

Resident of Gwinnett County



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920085129

to
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13

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

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

REPRINT IN PERMANENT BLACK INK

DECEDENT

INFORMANTS

FORMAL

POSITION

USE OF THIS

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) **ROBERT KALMAN SZILLAGE** 2. SEX **Male** 3a. TIME OF DEATH **7:59 A.M.** 3b. DATE OF DEATH (Month, Day, Yr) **December 2, 2005**

4. SOCIAL SECURITY NUMBER **[REDACTED]** 5a. AGE—Last Birthday (Years) **80** 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Mo, Day, Yr) **December 28, 1924** 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 **1945** 8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL Inpatient ER/Outpatient DOA OTHER Nursing Home Other (Specify) Residence

9a. FACILITY NAME (If not institution, give street and number) **Miller's Merry Manor** 9b. CITY, TOWN, OR LOCATION OF DEATH **Portage** 9c. COUNTY OF DEATH **Porter**

10. MARITAL STATUS (Specify) **Married** 11. SURVIVING SPOUSE (If wife, give maiden name) **Doris Williams** 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) **Bearing Repairman** 12b. KIND OF BUSINESS/INDUSTRY **Steel Industry**

13a. RESIDENCE—STATE **Indiana** 13b. COUNTY **Lake** 13c. CITY, TOWN, OR LOCATION **Merrillville** 13d. STREET AND NUMBER **524 W. 66th Place**

13e. ZIP CODE **46410** 13f. INSIDE CITY LIMITS No Yes 13g. ON A FARM? No Yes 14. CITIZEN OF WHAT COUNTRY? **USA** 15. WAS DECEDENT OF HISPANIC ORIGIN? No 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) **8** College (1-4 or 5+)

18. FATHER'S NAME (First, Middle, Last) **Kalman Szillage** 19. MOTHER'S NAME (First, Middle, Maiden Surname) **Josephine Kolic**

20a. INFORMANT'S NAME (Type/Print) **Doris Szillage** 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) **524 W. 66th Place, Merrillville, IN 46410** 20c. Relationship **Wife**

21a. METHOD OF DISPOSITION Burial Entombment Cremation Removal from State Donation Other (Specify) 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) **December 5, 2005 Calumet Park Cemetery** 21c. LOCATION—City or Town, State **Merrillville, Indiana**

22a. EMBALMER'S NAME **Ronald J. Mesarch** 22b. EMBALMER'S LICENSE NO. **FD01005912** 23. WAS DEATH REPORTED TO CORONER? No Yes

24a. SIGNATURE OF FUNERAL DIRECTOR *Ronald J. Mesarch* 24b. LICENSE NUMBER (of Licensee) **FD01005912** 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME **Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410**

25. 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) **Arteriosclerosis**

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Abdominal Aortic Aneurysm

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) CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. 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. 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 *[Signature]* 29c. MEDICAL LICENSE NO. **03001180** 29d. DATE SIGNED (Month, Day, Year) **12-6-05**

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) **Donald J. Maddack, D.O., 3125 Willowcreek Road, Portage, Indiana 46368**

31. HEALTH OFFICER'S SIGNATURE *[Signature]* 32. DATE FILED (Month, Day, Year) **December 6, 2005**

33. MANNER OF DEATH Natural Pending investigation Accident Suicides Could not be Determined 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.

