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2009 033422

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2009 MAY 19 AM 10:42

MICHAEL A. BROWN
RECORDER

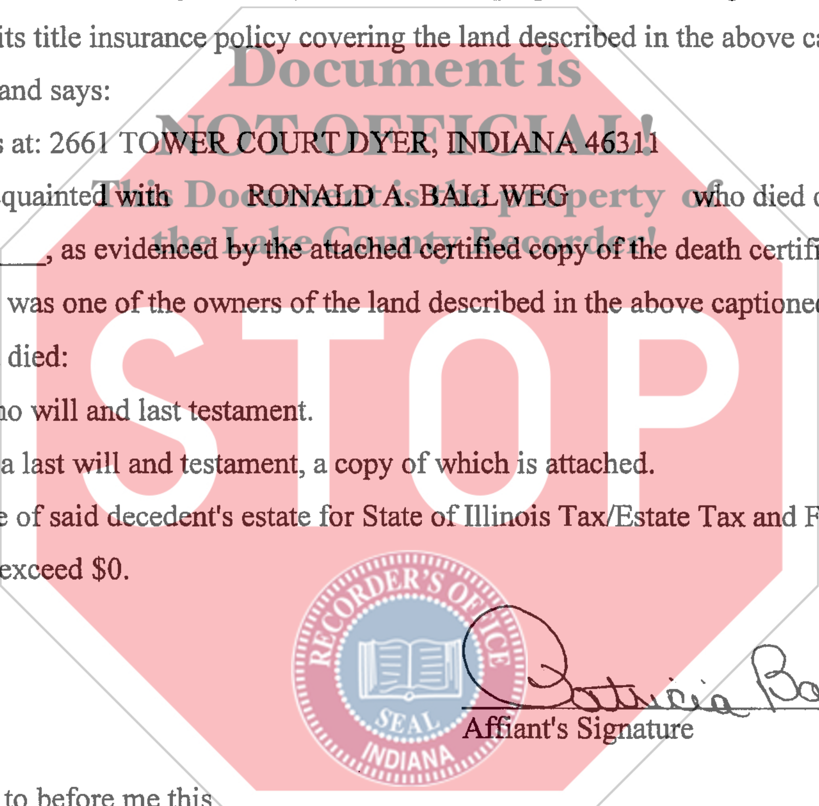
Deceased Joint Tenant Affidavit

State of INDIANA }
} ss.
County of LAKE County» }

Date: 5/11/2009

File No.: 09-438

PATRICIA D. BALLWEG , being first duly sworn, for the purpose of inducing Residential Title Services, Inc. to issue its title insurance policy covering the land described in the above captioned commitment, deposes and says:



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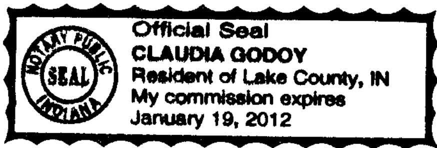
1. That he/she resides at: 2661 TOWER COURT DYER, INDIANA 46311
2. That he/she was acquainted with RONALD A. BALLWEG who died on 5-14-07, as evidenced by the attached certified copy of the death certificate.
3. That said decedent was one of the owners of the land described in the above captioned commitment.
4. That said decedent died:

   __X____ leaving no will and last testament.

   ________ leaving a last will and testament, a copy of which is attached.
5. That the total value of said decedent's estate for State of Illinois Tax/Estate Tax and Federal Estate Tax purposes does not exceed $0.

Patricia Ballweg
Affiant's Signature

Subscribed and sworn to before me this 11th day of May, 2009.



Notary Signature

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Hold for:
Residential Title

FILED
MAY 19 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER
MAY 19 2009
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

009551

#007275

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.

Local No. 1263-07

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

- 1. DECEASED–NAME (First, Middle, Last): RONALD ALFRED BALLWEG
- 2. SEX: MALE
- 3a. TIME OF DEATH: 11:27 AM
- 3b. DATE OF DEATH (Month, Day, Year): MAY 14, 2007
- 4. *SOCIAL SECURITY NUMBER: 375-36-5628
- 5a. AGE – Last Birthday (Years): 68
- 5b. UNDER 1 YEAR (Months, Days):
- 5c. UNDER 1 DAY (Hours, Minutes):
- 6. DATE OF BIRTH (Mo, Day, Yr): MARCH 21, 1939
- 7. BIRTHPLACE (City and State or Foreign Country): JAMESTOWN, N.D.
- 8a. WAS DECEDENT A U.S. VETERAN?: YES
- 8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1963
- 9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☒ Other (Specify) HOSPICE ☐ Residence
- 9b. FACILITY NAME (If not institution, give street and number): WILLIAM J. RILEY MEMORIAL 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): PATRICIA TINSLEY
- 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): STORE MANAGER
- 12b. KIND OF BUSINESS/INDUSTRY: SEARS - RETAIL
- 13a. RESIDENCE — STATE: INDIANA
- 13b. COUNTY: LAKE
- 13c. CITY, TOWN, OR LOCATION: DYER
- 13d. STREET AND NUMBER: 2661 TOWER CT.
- 13e. ZIP CODE: 46311
- 13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
- 13g. ON A FARM?: ☒ No ☐ Yes
- 14. CITIZEN OF WHAT COUNTRY?: U.S.A.
- 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): ; College (1-4 or 5+): 4

PARENTS

- 18. FATHER'S NAME (First, Middle, Last): ALFRED BALLWEG
- 19. MOTHER'S NAME (First, Middle, Maiden Surname): IRENE RINGUETTE

INFORMANT

- 20a. INFORMANT'S NAME (Type/Print): PATRICIA BALLWEG
- 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code): 2661 TOWER CT. DYER, INDIANA 46311
- 20c. Relationship: WIFE

DISPOSITION

- 21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)
- 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 18 2007 Chapel Lawn Cemetery
- 21c. LOCATION—City or Town, State: Schererville IN
- 22a. EMBALMER'S NAME: RICHARD MILLER
- 22b. EMBALMER'S LICENSE NO.: FD20400030
- 23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
- 24a. SIGNATURE OF FUNERAL DIRECTOR: Rick Miller
- 24b. LICENSE NUMBER (of Licensee): FD20400030
- 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FAGEN-MILLER FUNERAL HOME FH10200006, 8580 WICKER AVE. ST. JOHN, IN. 46373

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CAUSE OF DEATH

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)		Approximate Interval Between Onset and Death
a.	Metastatic Cancer of the Esophagus	10 Months
b.	DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.	DUE TO (OR AS A CONSEQUENCE OF):	

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

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): -

CERTIFIER

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: Barbara L Fuller, M.D.
- 29c. MEDICAL LICENSE NO.: 01034701
- 29d. DATE SIGNED (Month, Day, Year): 5/17/07
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Barbara L. Fuller, M.D. 801 MacArthur Blvd Ste 401 Munster, IN 46321

HEALTH OFFICER

- 31. HEALTH OFFICER'S SIGNATURE: Susan ... Best D.O.
- 32. DATE FILED (Month, Day, Year): May 18, 2007

- 33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ 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.

SDH06-004 State Form 10110 (R5/1-99)