



# Chicago Title Insurance Company

## SURVIVORSHIP AFFIDAVIT

Tax ID #45-10-01-333-017.000-034

BT1300983

On this 1/17/2014 before me personally appeared Margaret J. Quillici  
(insert date)

2014 JAN 29 AM 10:52:65

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

- Affiant resides at the address given below affiant's signature:
- Affiant is Daughter  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
- Said premises were formerly owned as joint tenants ~~or as tenants by the~~  
~~entireties~~ by Julius Lorince and Margaret J. Quillici

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
MICHAEL B. BROWN  
RECORDER  
2014 JAN 29 AM 10:53:33

- Said Julius Lorince  
(fill in name of co-tenant who died)  
died on 2/22/2012

leaving \_\_\_\_\_ will;  
(insert "a" or "no"; if will left, attach a copy)

- The legal description of the premises in question is:  
See Attached

**FILED**  
JAN 23 2014  
PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

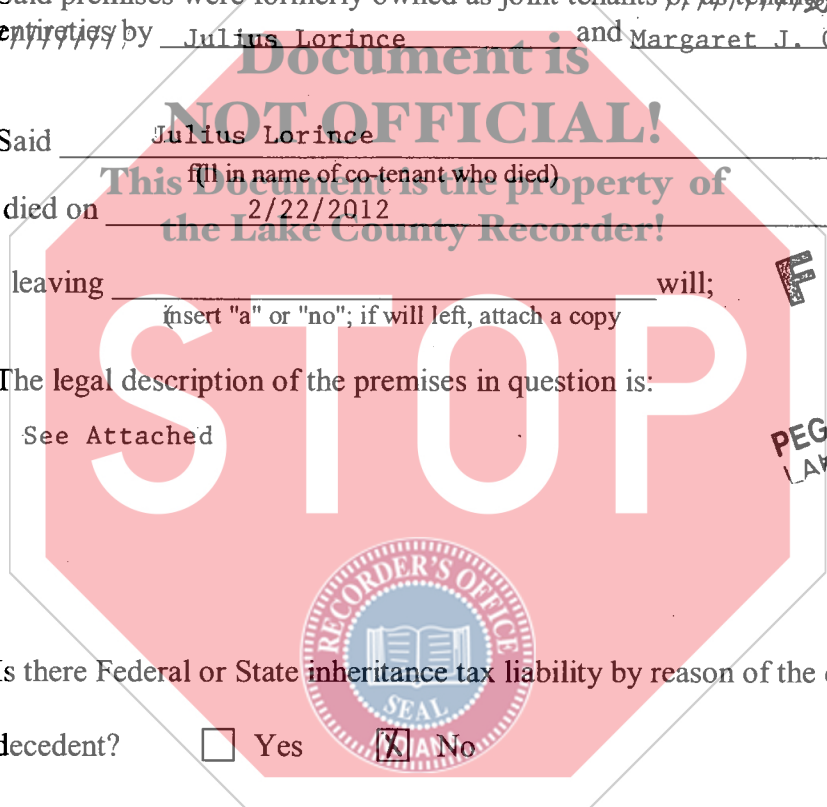
- Is there Federal or State inheritance tax liability by reason of the death of said decedent?  Yes  No

If yes, then estimated taxes due are \$ \_\_\_\_\_

The taxes due are  paid or  unpaid..

010346

CHICAGO TITLE INSURANCE COMPANY



18. -  
DN  
NON-COM

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

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

\_\_\_\_\_):

8. Affiant's relationship to the deceased was Daughter

Signature: Margaret J. Quilici

Printed Name Margaret J. Quilici

Address: 8429 STEPHEN CT  
WOODRIDGE IL 60517

Subscribed and sworn to before me by the affiant

This

1-17-14  
(insert date)

**Document is NOT OFFICIAL!**  
This Document is the property of the Lake County Recorder!

Karen Craig  
Notary Public



Printed Name \_\_\_\_\_

My County of Residence is: \_\_\_\_\_

In the State of \_\_\_\_\_

My Commission Expires \_\_\_\_\_

This instrument prepared by Margaret J. Quilici

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law L. Kurdelak



INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Tax ID #45-10-01-333-017.000-034

EDR No 00000246291

State No 007883

Local No 000547

|   |  |   |  |  |  |   |  |  |   |  |                               |  |
|---|--|---|--|--|--|---|--|--|---|--|-------------------------------|--|
| 1. Decedent's Legal Name (First, Middle, Last)<br><b>JULIUS LORINCE</b>   |  |   |  | 1a. Maiden Name (If Female)                                      |  | 2. Sex<br><b>MALE</b>   |  | 3. Time Of Death<br><b>06:15 AM</b>                      |   | 4. Date Of Death (Month/Day/Year)<br><b>02/22/2012</b>       |                               |  |
| 5. Social Security Number<br><b>172-32-0088 x</b>   |  | 8a. Age - Yrs<br><b>79</b>  |  | 6b. Under 1 Year   |  | 6c. Under 1 Month   |  | 6d. Under 1 Day  |   | 6e. Under 1 Hour   |                               |  |
| 7. Date of Birth (Month/Day/Year)<br><b>10/17/1932</b>  |  | 8. Birthplace (City and State or Foreign Country)<br><b>ADASCTEVEL, HU</b>  |  |  |  |   |  |  |   |  |                               |  |
| 9. Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 10. If Death Occurred In A Hospital:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival |  |  |  | 10a. If Death Occurred Somewhere Other Than A Hospital:<br><input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility <input type="checkbox"/> Other (Specify)                                |  |  |   |  |                               |  |
| 11. Facility Name: (If Not Institution, Give Street and Number)<br><b>ST MARGARET MERCY HEALTHCARE CENTERS-DYER</b>   |  |   |  |  |  |   |  |  |   |  |                               |  |
| 12. City Or Town, State, And Zip Code<br><b>DYER, IN, 46311</b>   |  |   |  |  |  | 13. County Of Death<br><b>LAKE</b>  |  |  | 14. Marital Status At Time Of Death<br><input type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown |  |                               |  |
| 15. Surviving Spouse's Name   |  |   |  | 15a. (If Wife) Give Maiden Last Name                             |  |   |  | 16. Decedent's Usual Occupation<br><b>OWNER OPERATOR</b> |   | 17. Kind Of Business/Industry<br><b>MACHINE AND GRINDING</b> |                               |  |
| 18. Residence - State<br><b>INDIANA</b>   |  |   | 18a. County<br><b>LAKE</b>   |  |  | 18b. City Or Town<br><b>DYER</b>  |  |  | 18d. Apt. No.   |  | 18e. Zip Code<br><b>46311</b> |  |
| 18c. Street And Number<br><b>1030 WILDFLOWER LANE</b>   |  |   | 18f. Inside City Limits?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  | 19. Decedent's Education<br><b>8TH GRADE OR LESS</b>  |  | 20. Decedent Of Hispanic Origin<br><b>NOT HISPANIC</b>   |   | 21. Decedent's Race<br><b>White</b>                          |                               |  |
| 22. Father's Name (First, Middle, Last)<br><b>JULIUS LORINZE</b>  |  |   |  | 23. Mother's Name (First, Middle, Last)<br><b>ZSOFIA LORINZE</b> |  |   |  | 23a. Mother's Maiden Last Name<br><b>LAMPERT</b>         |   |  |                               |  |
| 24. Informant's Name<br><b>MARGARET QUILICI</b>   |  |   | 24a. Relationship To Decedent<br><b>DAUGHTER</b>   |  |  | 24b. Mailing Address: (Street And Number, City, State, Zip Code)<br><b>8429 STEPHEN COURT, WOODRIDGE, IL 60517</b>  |  |  |   |  |                               |  |
| 25a. Method Of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal From State <input type="checkbox"/> Other (Specify)  |  |   | 25b. Place Of Disposition (Name Of Cemetery, Crematory, Other Place)<br><b>REGIONAL CREMATION SERVICE</b>  |  |  | 25c. Location - City, Town, And State<br><b>MUNSTER, IN</b>   |  |  |   |  |                               |  |
| 26. Was Coroner Contacted?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 27. Name And Complete Address Of Funeral Facility<br><b>KISH FUNERAL HOME, 10000 CALUMET AVE, MUNSTER, IN 46321</b>  |  |  |   |  |  | 27a. Funeral Home License Number<br><b>FH10700038</b>   |  |                               |  |
| 27b. Signature Of Indiana Funeral Service Licensee<br><b>KEVIN W. KISH, BY ELECTRONIC SIGNATURE</b>   |  |   | 27c. License Number (Of Licensee)<br><b>FD01021590</b>   |  |  |   |  |  |   |  |                               |  |
| 28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.<br><br>Immediate Cause (Final Disease Or Condition Resulting In Death)<br>A. <b>CEREBRAL ANOXIA</b> Due to (Or As A Consequence Of) <b>IMMEDIATE</b><br>B. <b>RESPIRATORY ARREST</b> Due to (Or As A Consequence Of)<br>C.<br>D.<br><br>Sequentially List Conditions, If Any, Leading To The Cause Listed On Line A. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last |  |   |  |  |  |   |  |  |   |  |                               |  |
| Part II. Enter Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I   |  |   |  |  |  | 29. Was An Autopsy Performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |                               |  |
| 31. Did Tobacco Use Contribute To Death?<br><input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown  |  |   | 32. If Female:<br><input type="checkbox"/> Not Pregnant Within Past Year <input type="checkbox"/> Pregnant At 1 year Of Death <input type="checkbox"/> Not Pregnant, But Pregnant Within 42 Days Of Death <input type="checkbox"/> Not Pregnant, But Pregnant 43 Days To 1 year Before Death <input type="checkbox"/> Unknown If Pregnant Within The Past Year |  |  | 33. Manner Of Death:<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined |  |  |   |  |                               |  |
| 34. Date Of Injury (Month/Day/Year)   |  |   | 35. Time Of Injury   |  |  | 36. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)   |  |  | 37. Injury At Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                               |  |
| 38. Location Of Injury - State  |  |   | 38a. City Or Town  |  |  | 38b. Street & Number  |  |  | 38c. Apt. No.   |  | 38d. Zip Code                 |  |
| 39. Describe How Injury Occurred  |  |   |  |  |  | 40. If Transportation Injury, Specify:<br><input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)  |  |  |   |  |                               |  |
| 41. Signature, Of Person Certifying Cause Of Death:<br><b>DWIN ARELLANO UDANI, BY ELECTRONIC SIGNATURE</b>  |  |   |  |  |  | 42. Certifier (Check Only One)<br><input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer   |  |  | 44. License Number<br><b>02001229A</b>  |  |                               |  |
| 43. Name, Address And Zip Code Of Person Certifying Cause Of Death:<br><b>DWIN ARELLANO UDANI, 221 S. US HWY 41 SUITE I, SCHERERVILLE, IN 46375</b>   |  |   |  |  |  | 45. Date Certified<br><b>02/23/2012</b>   |  |  | 47. *Alias:   |  |                               |  |
| 48. Signature of Local Health Officer:<br><b>USAN W. BEST, VIA ELECTRONIC SIGNATURE</b>   |  |   |  |  |  | 49. For Registrar Only - Date Filed (Month/Day/Year):<br><b>FEB 23 2012</b>   |  |  |   |  |                               |  |

AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

**EXHIBIT A**

**LEGAL DESCRIPTION**

THE NORTH 1/2 OF LOT 7 IN RESUBDIVISION OF PART OF LOT 1 HERITAGE ESTATES UNIT 6, TO THE TOWN OF DYER, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 74, PAGE 60 AND AMENDED BY CERTIFICATE OF CORRECTION RECORDED APRIL 20, 1994 AS DOCUMENT NO. 94-030153 AND FURTHER AMENDED BY CERTIFICATE OF CORRECTION RECORDED APRIL 8, 1994 AS DOCUMENT NO. 94-026673, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

