Corr 142763

Ticor - Highland

006640

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Sophie Orzechowicz, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Walter Orzechowicz died (without leaving a will) (~~with a will~~) on Feb. 19 19 88 at St. Margaret's Hospital

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate: That part of Lots 2, 3, 4, 5 and 6 lying Southwesterly of Marginal Street "D" adjacent to Indiana East and West Toll Road, except the South 14 feet of Lot 6 in Block 4 in Roxana Park 5th Addition, in the city of East Chicago, as per plat thereof, recorded in Plat Book 30 page 28, in the Office of the Recorder of Lake County, Indiana.

#30-609-3

3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (~~her~~) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

LILLIAN A. BLASTICK
RECORDER, LAKE COUNTY
CROWN POINT, INDIANA 46307
FILED FOR RECORD
Nov 10 8 59 AM '88

Sophie Orzechowicz
Sophie Orzechowicz

Subscribed and sworn to before me, a Notary Public, this 28th day of October, 19 88.

Linda J. McBride
Linda J. McBride Notary Public

My Commission expires:
1-26-91

County of Residence:
Lake

FILED

NOV 4 1988

Anna N. Anton
AUDITOR LAKE COUNTY

This Instrument prepared by Sophie Orzechowicz

Local No. 177

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

FEB 2 4 1988 Franklin [illegible] M.D.

Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME: First: Walter; Middle: ; Last: Orzechowicz
2 SEX: Male
3 DATE OF DEATH (Mo. Day, Yr.): February 19, 1988
4 SOCIAL SECURITY NUMBER: 313-14-0580
5a AGE—Last Birthday (Years): 66
5b UNDER 1 YEAR: Months / Days
5c UNDER 1 DAY: Hours / Minutes
6 DATE OF BIRTH (Month, Day, Year): May 26, 1921
7 BIRTHPLACE (City and State or Foreign Country): East Chicago, Ind.
8 YEAR LAST SERVED IN US ARMED FORCES?: 1945
9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL: XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c CITY, TOWN OR LOCATION OF DEATH: Hammond
9d COUNTY OF DEATH: Lake
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11 SURVIVING SPOUSE (If wife, give maiden name): S.Catherine (Dziald)
12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Storeroom Clerk
12b KIND OF BUSINESS/INDUSTRY: Engineering Co.
13a RESIDENCE—STATE: Indiana
13b COUNTY: Lake
13c CITY, TOWN OR LOCATION: East Chicago
13d STREET AND NUMBER: 5418 Reading Ave.
13e INSIDE CITY LIMITS? (Yes or no): Yes
13f FARM:
13g ZIP CODE: 46312
14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): X No ☐ Yes
15 RACE—American Indian, Black, White, etc. (Specify): White
16 DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17 FATHER'S NAME (First, Middle, Last): Joseph Orzechowicz
18 MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Hanba

INFORMANT

19a INFORMANT'S NAME (Type/Print): S.Catherine Orzechowicz
19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5418 Reading Ave., East Chicago, Ind.
19c Relationship: Wife

DISPOSITION

20a METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Feb.22,1988 Holy Cross Cem.
20c LOCATION—City or Town, State: Calumet City, Ill
21a SIGNATURE OF FUNERAL DIRECTOR: John B. Lesniak
21b LICENSE NUMBER (of Licensee): 100549-1
22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lesniak Funeral Home 300160 -1, 4918 Magoun Ave. E. Chicago, Ind.

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.
23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title: [signature] MD
23b LICENSE NUMBER: 20603
23c DATE SIGNED (Month, Day, Year): Feb. 22, 1988

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24 TIME OF DEATH: 3:15 p.M
25 DATE PRONOUNCED DEAD (Month, Day, Year): February 19, 1988
26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no):

CAUSE OF DEATH

27 PART I Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, 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)
a. Aspiration pneumonia
DUE TO (OR AS A CONSEQUENCE OF)
b. CVA (Cerebrovascular accident)
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

SEE INSTRUCTIONS

FILED NOV 4 1988

PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I
28a WAS AN AUTOPSY PERFORMED? (Yes or no)
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

[signature] Anton, AUDITOR LAKE COUNTY

CERTIFIER

29a CERTIFIER (Check only one)
X CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

29b SIGNATURE AND TITLE OF CERTIFIER: John M Adlard MD
29c LICENSE NUMBER: 28396
29d DATE SIGNED (Month, Day, Year): February 22, 1988
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): J.M. Adlard, M.D. 7905 Calumet Avenue, Munster, Indiana 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin [illegible] M.D.
32 DATE FILED (Month, Day, Year): FEB 2 4 1988

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CORONER OR MEDICAL EXAMINER USE ONLY

33 MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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):

Handwritten in left margin: Roxana Park 5th Addn. Lot [illegible] Blk 2 Ward 4 #30-608-3

SBH06-004 State Form 10110 Rev 10/87 DEATH/PD 1