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STATE OF INDIANA)
) SS: **AFFIDAVIT**
COUNTY OF LAKE)

The undersigned, **HALINA ULINSKI**, being first duly sworn upon her oath, deposes and states as follows:

1. That I have personal knowledge as to the contents of this Affidavit.

2. That Stanley Prokocki died May 11, 1988 in Dyer, Indiana, a copy of Death Certificate is attached hereto; that the decedent died intestate.

3. That the decedent's Estate was not subject to a federal estate tax.

4. That Stanley Prokocki acquired, together with his wife, Angeline Prokocki, the following described real estate:

Lot 18 in Candlelight Trails 1st Addition to the Town of St. John, as per plat thereof, recorded in Plat Book 44, page 135, in the Office of the Recorder of Lake County, Indiana.

#13-66-19

5. That on the date of acquisition of said real estate, Angeline Prokocki and Stanley Prokocki were husband and wife, and they remained husband and wife until the date of Stanley Prokocki's death on May 11, 1988.

I affirm under the penalties of perjury, that the aforesaid representations are true.

Halina Ulinski
HALINA ULINSKI

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED FOR RECORD
ROBERT L. MEINZER
RECORDER
Feb 8 3 58 PM '90

SUBSCRIBED AND SWORN to before me, a Notary Public, this 5 day of January, 1990.

My Commission Expires
July 18, 1993
Resident of Lake County

ROBERT L. MEINZER, JR.
NOTARY PUBLIC

THIS INSTRUMENT WAS PREPARED BY ROBERT L. MEINZER, JR.

FILED

FEB 1990

Auditor Lake County

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TICOR TITLE INSURANCE
Highland, Indiana

TICOR TITLE INSURANCE
Crown Point, Indiana
HC
151206

Local No. 1048-88

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME: First: Stanley; Middle: ; Last: Prokocki
2. SEX: Male
3. DATE OF DEATH (Mo., Day, Yr.): May 11, 1988
4. SOCIAL SECURITY NUMBER: 308-14-4482
5a. AGE—Last Birthday (Years): 74
5b. UNDER 1 YEAR: Months: ; Days:
5c. UNDER 1 DAY: Hours: ; Minutes:
6. DATE OF BIRTH (Month, Day, Year): May 7, 1914
7. BIRTHPLACE (City and State or Foreign Country): East Chicago, IN
8. YEAR LAST SERVED IN U.S. ARMED FORCES: 1946
9a. PLACE OF DEATH (Check only one. See instructions.)
HOSPITAL: ☐ Inpatient ☒ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Our Lady of Mercy Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Dyer
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Angeline Biel
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Welder
12b. KIND OF BUSINESS/INDUSTRY: Tank Manufacturer
13a. RESIDENCE—STATE: Indiana
13c. COUNTY: Lake
13d. CITY, TOWN, OR LOCATION: St. John
13e. STREET AND NUMBER: 9662 Olcott Avenue
13f. INSIDE CITY LIMITS? (Yes or no): Yes
13g. FARM: No
13h. ZIP CODE: 46373
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): Stanislaw Prokocki
18. MOTHER'S NAME (First, Middle, Maiden, Surname): Mariana Matsc

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Angeline Prokocki
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9662 Olcott Ave. St. John, IN 46373
19c. Relationship: Wife

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): May 14, 1988 Holy Cross Cemetery
20c. LOCATION—City or Town, State: Calumet City, Illinois
21a. SIGNATURE OF FUNERAL DIRECTOR: Larry D. Anthony
21b. LICENSE NUMBER (Of Licensee): FL1001447
22. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Anthony & Dziadowicz FDH3002916 9445 Calumet, Munster, IN 46321

PRONOUNCING PHYSICIAN ONLY

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

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
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)
24. TIME OF DEATH: 12:08 P.M.
25. DATE PRONOUNCED DEAD (Month, Day, Year): May 11, 1988
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No): Yes

SEE INSTRUCTIONS

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.
a. IMMEDIATE CAUSE (Final disease or condition resulting in death): Coronary insufficiency
b. DUE TO (OR AS A CONSEQUENCE OF): Due to arteriosclerotic heart & vascular disease
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death: Unknown

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

CAUSE OF DEATH

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): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

SEE INSTRUCTIONS

29a. CERTIFIER (Check only one)
☐ 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: Daniel D. Thomas
29c. LICENSE NUMBER: 16120
29d. DATE SIGNED (Month, Day, Year): May 12, 1988
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DANIEL D. THOMAS, M.D., CORONER, 2293 N. MAIN ST., CROWN POINT, IN. 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE:
32. DATE FILED (Month, Day, Year): MAY 12, 19

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)

SBH06-004 State Form 10110 Rev 10/87 DEATH-P01

FILED
FEB 1990
Auditor Lake County

Candlelight Trails 1st Add St John
Lt 18 #12-66-19

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