15 19 18
Opost

096406

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Delphine Lebryk, sister of Paul J. Synosh, being first duly sworn upon oath, deposes and says:

1. That ~~Affiant's~~ Paul J. Synosh's spouse, DOROTHY SYNOSH also known as Dorothy L. Synosh died (without leaving a will) ~~(leaving a will)~~ on May 25 19 88 at St. Margaret 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: 32-195-

Lot 7 in Bloomberg's Second Addition, in the City of Hammond, as per plat thereof, recorded in Plat Book 29 page 20, in the Office of the Recorder of Lake County, Indiana.

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.

Delphine Lebryk
DELPHINE LEBRYK

Subscribed and sworn to before me, a Notary Public, this 28th day of March, 1990.

Jean McMichael
Jean McMichael Notary Public

My Commission expires: 12-3-93

County of Residence: Lake

This Instrument prepared by DELPHINE LEBRYK

FILED
APR 18 1990
Anna N. Anton
AUDITOR LAKE COUNTY

APR 13 8 57 AM '90
ROBERT "BUD" CROWN
RECORDER

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
FILED FOR RECORD

TICOR TITLE INSURANCE
Highland, Indiana

000581

5.50
+1

Local No. 471

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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

Franklin D. Jemudas M.D.

MAY 26 1988 Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First / Middle / Last)			2 SEX	3 DATE OF DEATH (Mo. Day Yr.)
DOROTHY	L.	SYNOSH	Female	May 25, 1988

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months / Days	5c UNDER 1 DAY Hours / Minutes	6 DATE OF BIRTH (Month, Day, Year)	7 BIRTHPLACE (City and State or Foreign Country)
347-12-3932	64			Feb. 6, 1925	Harrisburg, Illinois

8 YEAR LAST SERVED IN US ARMED FORCES? none

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)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
St. Margaret Hospital	Hammond	Lake

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Paul Synosh	Homemaker	Own Home

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	7116 California

13e INSIDE CITY LIMITS? (Yes or no)	13f FARM	13g ZIP CODE	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] No [ ] Yes Specify NO	15 RACE—American Indian, Black, White, etc. (Specify)	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+)
yes	no	46323		White	secondary

PARENTS

17 FATHER'S NAME (First, Middle, Last)	18 MOTHER'S NAME (First, Middle, Maiden Surname)
Ray Sherfield	Ella unavailable

INFORMANT

19a INFORMANT'S NAME (Type/Print)	19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	19c Relationship
Mr. Paul Synosh	7116 California Hammond, Indiana 46323	Husband

DISPOSITION

20a METHOD OF DISPOSITION	20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	20c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	May 27, 1988 St. Joseph Cemetery	Hammond, Indiana

21a SIGNATURE OF FUNERAL DIRECTOR — 21b LICENSE NUMBER (If Licensed) FDE1013507 — 22 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Bocken Funeral Home, Inc. FDH3002801, 7042 Kennedy Avenue Hammond, Indiana 46323

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 and due to the cause(s) and manner as stated. Signature and Title	23b LICENSE NUMBER	23c DATE SIGNED (Month, Day, Year)
A. LABRADOR, M.D.	0102 9371	May 25, 1988

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

24 TIME OF DEATH	25 DATE PRONOUNCED DEAD (Month, Day, Year)	26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)
4:24 AM	5/25/88 May 25, 1988	No

SEE INSTRUCTIONS

CAUSE OF DEATH

27. PART I. Enter the disease, 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death)	Approximate Interval Between Onset and Death
a. LUNG CANCER	
DUE TO (OR AS A CONSEQUENCE OF)	
b. ADULT RESPIRATORY DISTRESS SYNDROME	
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

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)
no	

FILED APR 18 1990

SEE INSTRUCTIONS

CERTIFIER

29a CERTIFIER (Check only one)

[X] CERTIFYING PHYSICIAN (Physician certifying cause of death when another person has pronounced death and listed in 23) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. AUDITOR LAKE COUNTY

[ ] 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	29c LICENSE NUMBER	29d DATE SIGNED (Month, Day, Year)
	35201	May 26, 1988

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type/Print): C.J. Sanders, M.D. 7905 Calumet Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Jemudas M.D. — 32. DATE FILED (Month, Day, Year): MAY 26 1988

CORONER OR MEDICAL EXAMINER USE ONLY

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) 000582

SBH06-004 State Form 10110 (R/10-87) DEATH A/PD I