Com 15-2667

103275

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

GLORIA J. FEMIAK, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, DANIEL J. FEMIAK died (without leaving a will) (~~leaving a will~~) on September 11 19 89 at Crown Point, Indiana

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 19 in Sandpiper Unit No. 1, in the Town of Merrillville, as per plat thereof, recorded in Plat Book 47 page 132, in the Office of the Recorder of Lake County, Indiana.

15-477-19

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STOP

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.

Gloria J. Femiak
GLORIA J. FEMIAK

Subscribed and sworn to before me, a Notary Public, this 18th day of May, 19 90.

Paula Barrick
PAULA BARRICK Notary Public

My Commission expires:
10-2-93

County of Residence:
Lake

FILED

MAY 25 1990

Anna N. Anton
AUDITOR LAKE COUNTY

This Instrument prepared by GLORIA J. FEMIAK

550

001451

152667

Local No. 4152-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): DANIEL J. FEMIAK
2. SEX: MALE
3a. TIME OF DEATH: 3:30 P M
3b. DATE OF DEATH (Month, Day, Yr): SEPTEMBER 11, 1989
4. SOCIAL SECURITY NUMBER: 316-24-5904
5a. AGE—Last Birthday (Years): 59
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): OCT 8, 1929
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?:
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL XX Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. ANTHONY'S HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: CROWN POINT
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): GLORIA J. KEMP
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): SELF-EMPLOYED
12b. KIND OF BUSINESS/INDUSTRY: CONTRACTOR
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: CROWN POINT
13d. STREET AND NUMBER: 9253 VIGO STREET
13e. ZIP CODE: 46307
13f. INSIDE CITY LIMITS: ☐ No XX Yes
13g. ON A FARM?: XX No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: XX 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): DANIEL J. FEMIAK
19. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA A. LENGYL

INFORMANT

20a. INFORMANT'S NAME (Type/Print): GLORIA J. FEMIAK
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9253 VIGO STREET, CROWN POINT, IN 46307
20c. Relationship: SPOUSE

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): SEPTEMBER 15, 1989 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FD01004194
23. WAS DEATH REPORTED TO CORONER?: XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD01041083
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME, INC. FDH3003069 600 W. RIDGE ROAD, HOBART, IN 46342

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

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): a. Pancreatic Cancer

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

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

Approximate Interval Between Onset and Death

1989

[signature]
LAKE COUNTY HEALTH COMMISSIONER

PART II. Other significant conditions — Conditions contributing to death but not previously related to Part I.

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): N/A
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): N/A

CERTIFIER

29a. CERTIFIER (Check only one)
XX 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: R. E. Drasga
29c. MEDICAL LICENSE NO.: 01031484
29d. DATE SIGNED (Month, Day, Year): 09-14-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RAY E. DRASGA, MD, 8127 MERRILLVILLE ROAD, MERRILLVILLE, IN 46410

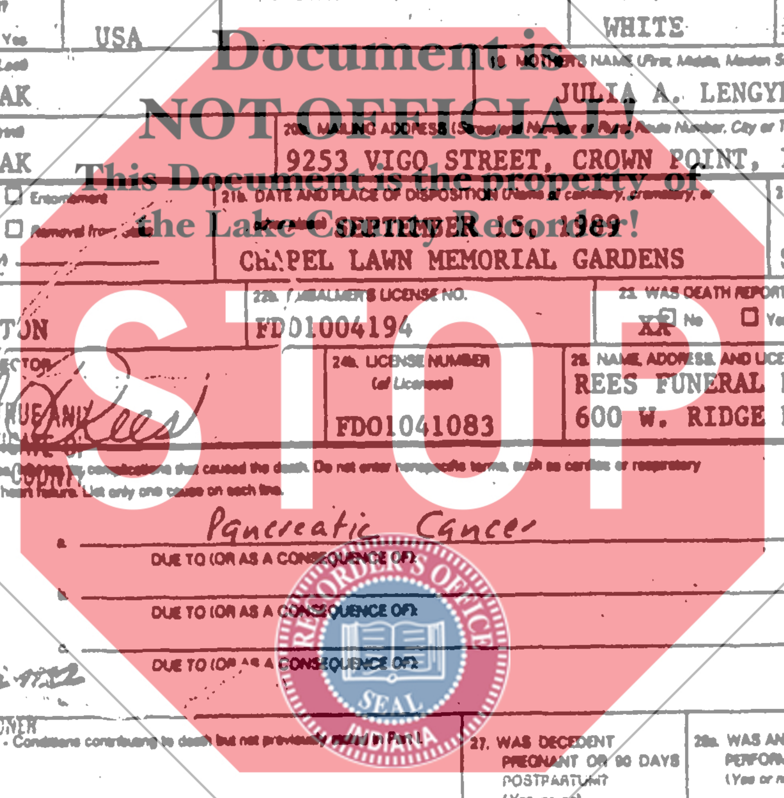
HEALTH OFFICER

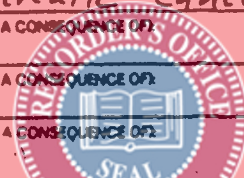
31. HEALTH OFFICER'S SIGNATURE: [signature]
32. DATE FILED (Month, Day, Year): Sept. 14, 1989

CORONER 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):
34g. DATE PRONOUNCED DEAD (Month, Day, Year):
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1





TICOR TITLE INSURANCE