

Ret to file

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AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA, S.S. NO. _____
LAKE COUNTY
RECORDS
Dec 10 8 49 AM '90
RECORDED

Ann Locasto, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Anthony Locasto died (without leaving a will) (~~leaving a will~~) on January 31, 1989 at METHODIST HOSPITAL SOUTHWALK, HEARLEYSVILLE, IN.

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

Key # #2 = 243-35

Lot 39 and the East 3.77 feet of Lot 38, Block 17, in Earle's Third Glen Park Addition to Gary, as per plat thereof, recorded in Plat Book 9, page 36, 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 ~~their~~ 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 bank accounts and life insurance on decedent's life were sufficient to necessitate payment of Federal Estate Tax.

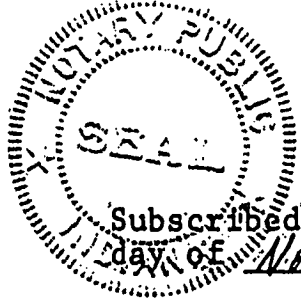


FILED

NOV 30 1990

Further affiant sayeth not

Anna N. Anton
AUDITOR LAKE COUNTY



Ann D. Locasto
Ann Locasto

Subscribed and sworn to before me, a Notary Public, this 15th day of NOVEMBER, 1990.

Ernest E. Wheeler
Ernest E. Wheeler Notary Public

My Commission expires:
June 22, 1994

County of Residence:
Lake

This Instrument prepared by Ann Locasto

001445

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TIGER TITLE INSURANCE
Carmel, Indiana

INDIANA STATE BOARD OF HEALTH

156780

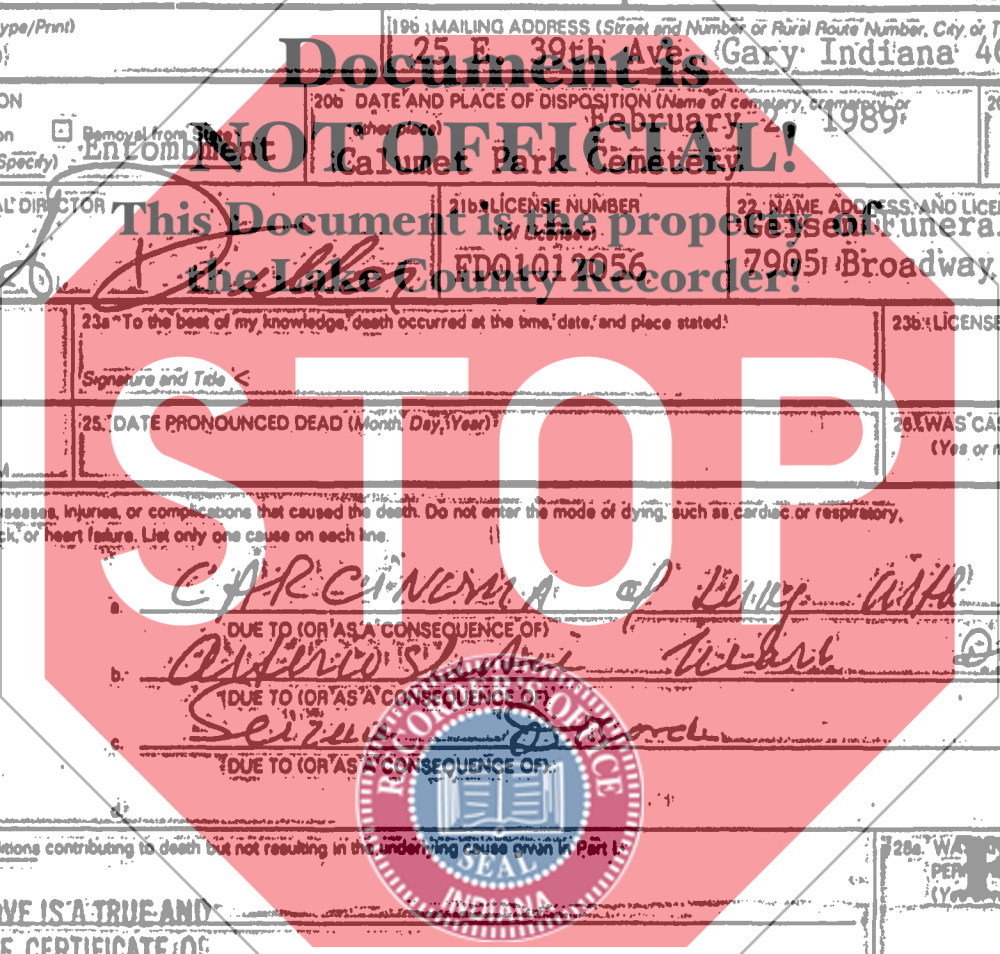
Local No. 92-89

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK DECEASED PARENTS INFORMANT DISPOSITION PRONOUNCING PHYSICIAN ONLY ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH SEE INSTRUCTIONS SEE INSTRUCTIONS CERTIFIER HEALTH OFFICER CORONER OR MEDICAL EXAMINER USE ONLY

1 DECEASED—NAME FIRST MIDDLE LAST Anthony Michael Locasto			2 SEX Male	3 DATE OF DEATH (Mo. Day Yr) January 30, 1989	
4 SOCIAL SECURITY NUMBER 313-18-5067	5a AGE—Last Birthday (Years) 65	5b UNDER 1 YEAR Months: Days: Hours: Minutes:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Month, Day, Year) April 22, 1923	7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois
8 YEAR LAST SERVED IN US ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
9b FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake Campus		9c CITY, TOWN, OR LOCATION OF DEATH Merrillville		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) Married	11a SURVIVING SPOUSE (If wife, give maiden name) Ann Glibota	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Bartender		12b KIND OF BUSINESS/INDUSTRY Restaurant	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Gary		13d STREET AND NUMBER 25 E. 39th Avenue	
13e INSIDE CITY LIMITS? (Yes or no) Yes	13f FARM No	13g ZIP CODE 46409	14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes. If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:	15 RACE—American Indian, Black, White, etc. (Specify) White	16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (13-16 or S+)
17 FATHER'S NAME (First, Middle, Last) Epifano Locasto			18 MOTHER'S NAME (First, Middle, Maiden Surname) Ann Elizabeth Farano		
19a INFORMANT'S NAME (Type/Print) Ann Locasto		19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 E. 39th Ave. Gary, Indiana 46409		19c Relationship Wife	
20a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematorium, or other place) February 2, 1989 Calumet Park Cemetery		20c LOCATION—City or Town, State Merrillville, In.	
21a SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. ...</i>		21b LICENSE NUMBER FD01012056		22 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Funeral Home, Inc. PH18007762 7905 Broadway Merrillville, In. 46410	
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 3:30 A.		25 DATE PRONOUNCED DEAD (Month, Day, Year)		26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no) No	
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. CAR CINCENMA of Lung with Wilk. Asthma, Seizure, Dissecting Aortic Aneurysm					
27 PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I					
28a WAY OF DEATH (Yes or no) FILED			28b TO OPSV FINDINGS PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
29 THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed health certificate) To the best of my knowledge, death occurred due to the cause(s) and manner as stated. FEB 2 1989					
29a 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. Ann N. Anton AUDITOR LAKE COUNTY					
29b SIGNATURE AND TITLE OF CERTIFIER <i>Ann N. Anton</i> LAKE COUNTY HEALTH COMMISSIONER		29c LICENSE NUMBER 01023583	29d DATE SIGNED (Month, Day, Year) 1/31/89		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Raffy Hovanessian M.D. 7863 Broadway Merrillville, In. 46410					
31 HEALTH OFFICER'S SIGNATURE <i>Keith D. ...</i>				32 DATE FILED (Month, Day, Year) Feb 1, 1989	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)	34b SOURCE 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)	



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