

FILED

4-4398  
R61917

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FEB 26 1991

STATE OF INDIANA )  
                          )SS:  
COUNTY OF LAKE )

*Anna M. Anton*

AFFIDAVIT OF SURVIVORSHIP LAKE COUNTY

Lois Romanchek, after being duly sworn upon her oath states as follows:

1. That on the 15th day of February, 1964 she was duly married to Walter E. Romanchek.

2. During their marriage, they together as husband and wife purchased the real estate located at 4153 Oakmont Court, Crown Point, Indiana, more particularly described as:

Unit No. 2, Lot 565, Lakes of the Four Seasons, Lake County, Indiana.

Key No. 10-46-277, Unit 11.

3. Walter Romanchek died intestate on the 26th day of December, 1990. No estate has been opened for Walter Romanchek nor is one contemplated nor planned to be opened. No state nor federal inheritance or estate taxes are due and owing. A certified copy of Walter E. Romanchek's certified death certificate is attached hereto.

4. Lois Romanchek is the sole heir at law entitled to inherit the above described real estate.

Dated this 19<sup>th</sup> day of <sup>FEBRUARY</sup> January 1991.

*Lois Romanchek*  
Lois Romanchek, Affiant

STATE OF INDIANA )  
                          )SS:  
COUNTY OF LAKE )

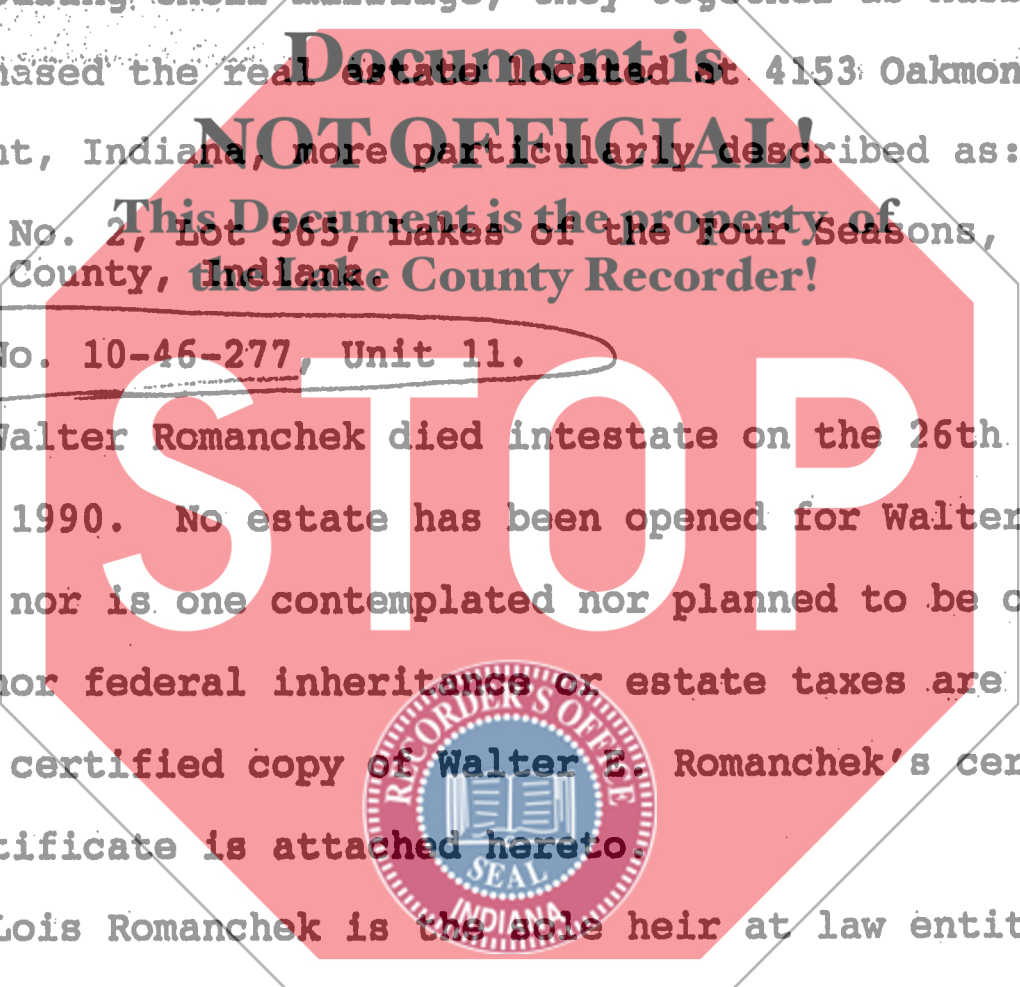
Before me, the undersigned, a Notary Public, in and for

C1593

INDIANA DIVISION  
TITLE INSURANCE COMPANY  
STATE OF INDIANA/S.S. NO.  
LAKE COUNTY  
FILED FOR RECORDING

FEB 29 10 20 AM '91

ROBERT RECORDS



*M*

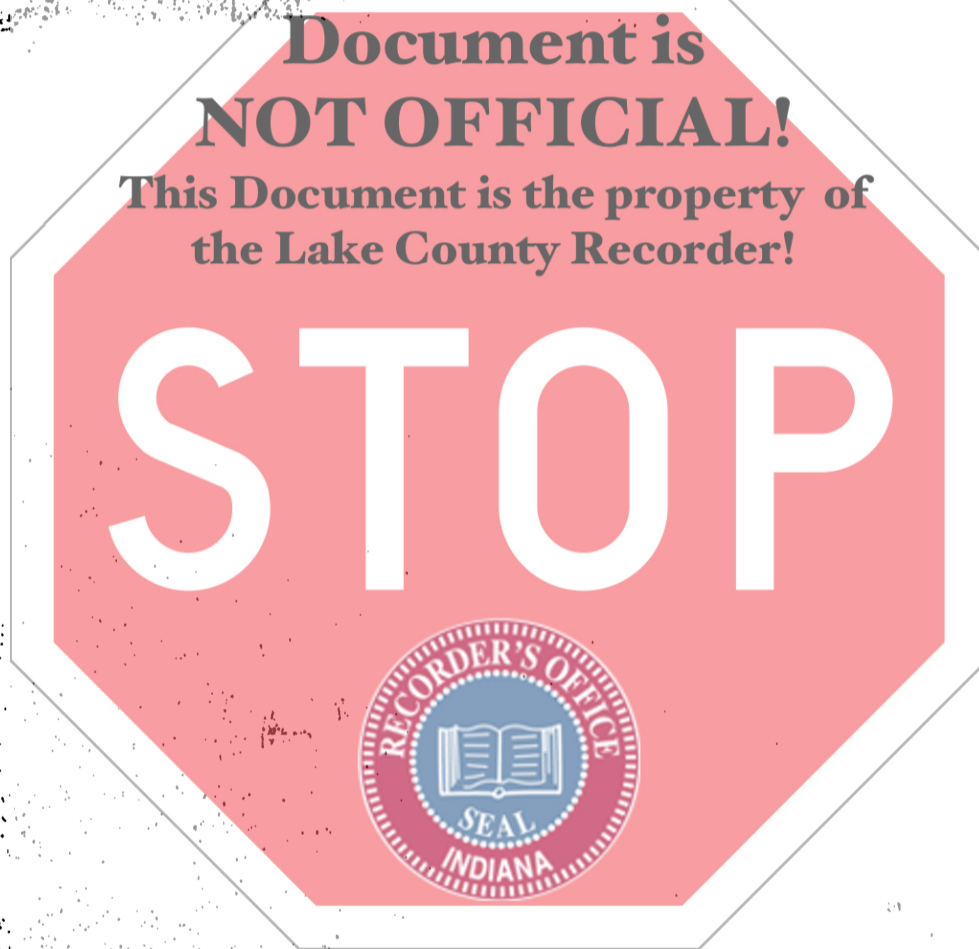
*10-00  
10-01*

said County and State, personally appeared Lois Romanchek, Affiant and acknowledged the execution of said Affidavit of Survivorship to be her voluntary act and deed for the uses and purposes expressed therein.

WITNESS MY HAND AND SEAL, this 19<sup>th</sup> day of FEBRUARY, ~~January~~

1991.  
NOTARY PUBLIC  
My Commission Expires:  
SEP. 30 1993

Debra S. Volk  
Debra L. Volk, Notary Public  
Resident of Porter County, IN



This Instrument Prepared By: Nick J. Anast, TOKARSKI & ANAST, 7803 West 75th Avenue, Suite 1, Schererville, IN 46375, 219/769-7214 or 322-1271

2042

4-4398  
R61917

# INDIANA STATE BOARD OF HEALTH

## CERTIFICATE OF DEATH

Local No. 2586-90

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

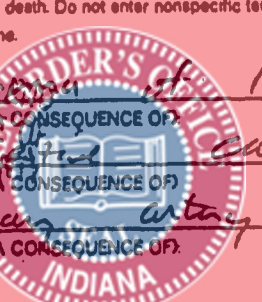
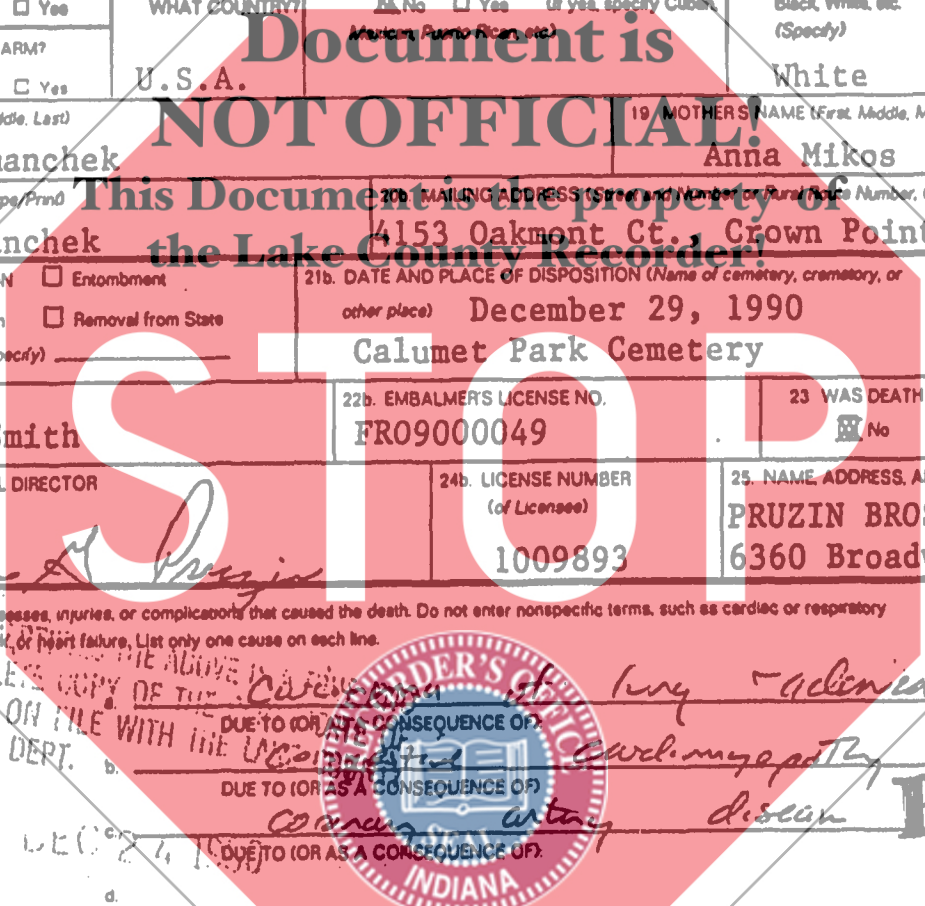
CERTIFIER

HEALTH  
OFFICER

CORONER  
USE ONLY

1. DECEASED—NAME (First, Middle, Last) <b>WALTER E. ROMANCHEK</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>8:00 a.m.</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>December 26, 1990</b>
4. SOCIAL SECURITY NUMBER <b>312-28-8594</b>	5a. AGE—Last Birthday (Years) <b>59</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>November 20, 1931</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1953</b>	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b. FACILITY NAME (If not institution, give street and number) <b>St. Anthony Medical Center</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>Crown Point</b>	9d. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Lois J. Dailey</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>self-employed</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Floor Covering</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Crown Point</b>	13d. STREET AND NUMBER <b>4153 Oakmont Court</b>	
13e. ZIP CODE <b>46307</b>	13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, American, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13 or more) <b>2</b>		18. FATHER'S NAME (First, Middle, Last) <b>James D. Romanchek</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Mikos</b>		20. INFORMANT'S NAME (Type/Print) <b>Lois J. Romanchek</b>		
20a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4153 Oakmont Ct., Crown Point, IN 46307</b>		20c. Relationship <b>Wife</b>		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>December 29, 1990 Calumet Park Cemetery</b>		21c. LOCATION—City or Town, State <b>Merrillville, Indiana</b>
22a. EMBALMER'S NAME <b>William D. Smith</b>		22b. EMBALMER'S LICENSE NO. <b>FR09000049</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas A. Pruzin</i>		24b. LICENSE NUMBER (of Licensee) <b>1009893</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410</b>	
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. <b>Myocardial infarction</b> <b>1 year</b> <b>1 year</b> <b>1 year</b>		Approximate Interval Between Onset and Death		
PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I.		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> 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. <input type="checkbox"/> 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.		29c. MEDICAL LICENSE NO. <b>31712</b>		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Ziegler</i>		29d. DATE SIGNED (Month, Day, Year) <b>12-26-90</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Jack H. Ziegler, M.D., 8909 Broadway, Merrillville, Indiana 46410</b>		769-1444		
31. HEALTH OFFICER'S SIGNATURE <i>Robert Guthrie</i>		32. DATE FILED (Month, Day, Year) <b>Dec. 26, 1990</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> 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) <b>015317</b>		34g. DATE PRONOUNCED DEAD (Month, Day, Year)		
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.				

Key # 10-46-277 Lake of the Four Seasons Unit No. 2 L.S. 65



**FILED**

**FEB 26 1991**