



SURVIVORSHIP AFFIDAVIT

STATE OF Indiana

COUNTY OF Lake

s. s.

On this April 5, 1991 before me personally appeared Helen Rozina
(insert date)

also known as Helen L. Rozina

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;

2. Affiant is owner
(state interest of affiant in the above premises as "owner," "son of owner," etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by

Pete Rozina and Helen Rozina;

4. Said Pete Rozina
(fill in name of co-tenant who died)

died on January 29, 1990

leaving no will
(insert "a" or "no" if will left, attach a copy)

5. The legal description of the premises in question is:

Lot 27, Block 2, Re-Division of Riverview Addition, in the City of Hammond, as shown in Plat Book 19, page 31, in Lake County, Indiana commonly known as 7608 Madison Avenue, Hammond, Indiana 46324.

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent: none

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?
no

(If answer is "Yes," identify the divorce proceedings:
_____)

8. Affiant's relationship to the deceased was wife

Signature Helen L. Rozina
Helen L. Rozina

Address: 7606 Madison Avenue
Hammond, Indiana 46324

Subscribed and sworn to before me by the affiant

FILED

this April 5, 1991
(insert date)

APR 11 1991

Virginia L. Rozynek
Notary Public
Indiana

Anna N. Anton
AUDITOR LAKE COUNTY

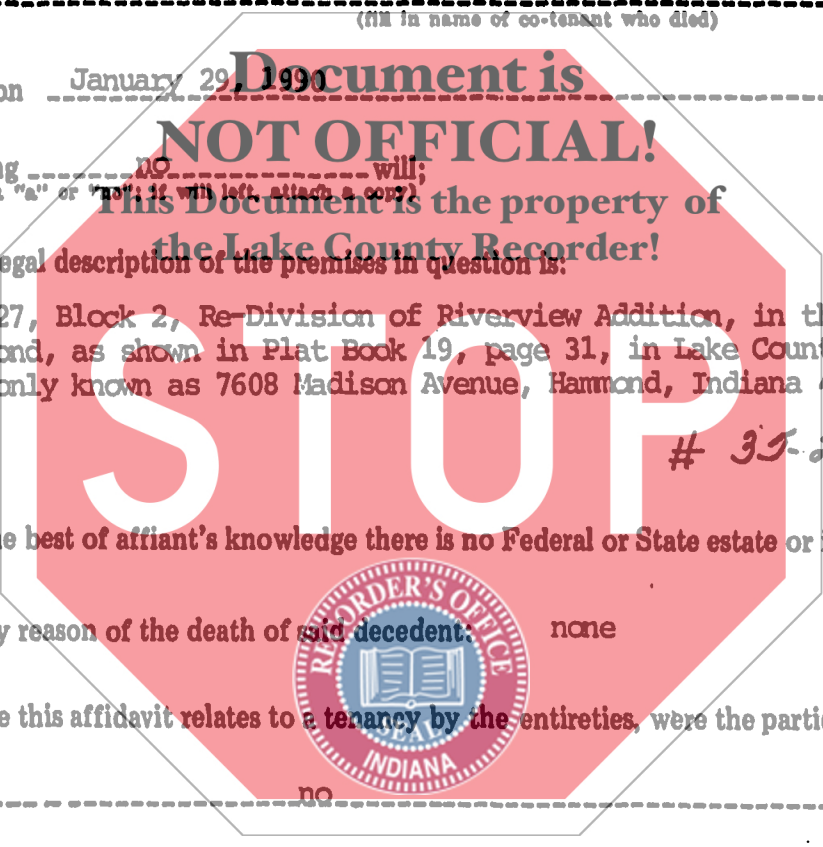
My Commission Expires November 4, 1994

00628

This instrument prepared by Helen Rozina

CHICAGO TITLE INSURANCE COMPANY
INDIANA DIVISION

STATE OF INDIANA/S.S. NO.
LAKE COUNTY
APR 12 1 23 PM '91
ROBERT RECORDER



900
of

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 304-90

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

RENTS

FORMANT

POSITION

USE OF
ATH

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RONER
E ONLY

INDIANA
DIVISION

1. DECEASED—NAME (First, Middle, Last) PETE ROZINA		2. SEX MALE	3a. TIME OF DEATH 8:00 A.M.	3b. DATE OF DEATH (Month, Day, Yr) JANUARY 29, 1990
4. SOCIAL SECURITY NUMBER 306-03-5059	5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) MAY 16, 1908
7. BIRTHPLACE (City and State or Foreign Country) KEWANEE, ILLINOIS	8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	8c. 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	
9a. FACILITY NAME (If not institution, give street and number) OUR LADY OF MERCY HOSPITAL		9b. CITY, TOWN, OR LOCATION OF DEATH DYER	9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) HELEN L. (ELLIOTT)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SUPERVISOR		12b. KIND OF BUSINESS/INDUSTRY INLAND STEEL CO.
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND	13d. STREET AND NUMBER 2706 MADISON AVENUE	
13e. ZIP CODE 46324	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12 yrs College (1-4 or 5+) 3 yrs		18. FATHER'S NAME (First, Middle, Last) ELI ROZINA		
19. MOTHER'S NAME (First, Middle, Maiden Surname) JULIA KOVACH			20a. INFORMANT'S NAME (Type/Print) HELEN L. ROZINA	
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7606 MADISON AVENUE, HAMMOND, IND. 46324		20c. Relationship WIFE		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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, funeral home, or other place) FEBRUARY 2, 1990 CHAPEL LAWN CEMETERY		21c. LOCATION—City or Town, State SCHERERVILLE, IND.
22a. EMBALMER'S NAME CHARLES W. WELLS,		22b. EMBALMER'S LICENSE NO. #1042372	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Anthony Solan</i>		24b. LICENSE NUMBER (of Licensee) FDE#1051840	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME SOLAN FUNERAL HOME #3002893 7109 CALUMET AVE., HAMMOND, IND. 46324	
26. PART I. Enter the disease, 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. Cardiopulmonary Arrest Ruptured Esophageal Varices Gastric Carcinoma with liver metastasis				Approximate Interval Between Onset and Death Seconds minutes Months
PART II. Other significant conditions contributing to death but not previously stated in Part I. APR 11 1991				27. WAS DECEDENT PHUNANT 20H W3 DAYS POSTPARTUM? (Yes or no) no
28a. WAS AN AUTOPSY PERFORMED? (Yes or no) no		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CHORNER		To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Johnson</i> LAKE COUNTY HEALTH COMMISSIONER		29c. MEDICAL LICENSE NO. 02000872	29d. DATE SIGNED (Month, Day, Year) JAN. 30, 1990	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) JOHN A. HOEHN, D.O., 13 W. LINCOLN HIGHWAY, SCHERERVILLE, IND. 46375				
31. HEALTH OFFICER'S SIGNATURE <i>Paul Johnson</i>				32. DATE FILED (Month, Day, Year) Jan 30, 1990
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending <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) Jan 27, 1990	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) Rediv. of River view add R. 27 Pl 2 #35-291-27		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. no		

LOT 27, B 21, R. 2 Sub River view Add
pp 19/31

