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TICOR TITLE INSURANCE

AFFIDAVIT

91021078

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Anne Graden, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Stephen Graden died (without leaving a will) (leaving a will) on 7-20-1990 at Merrillville, 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:

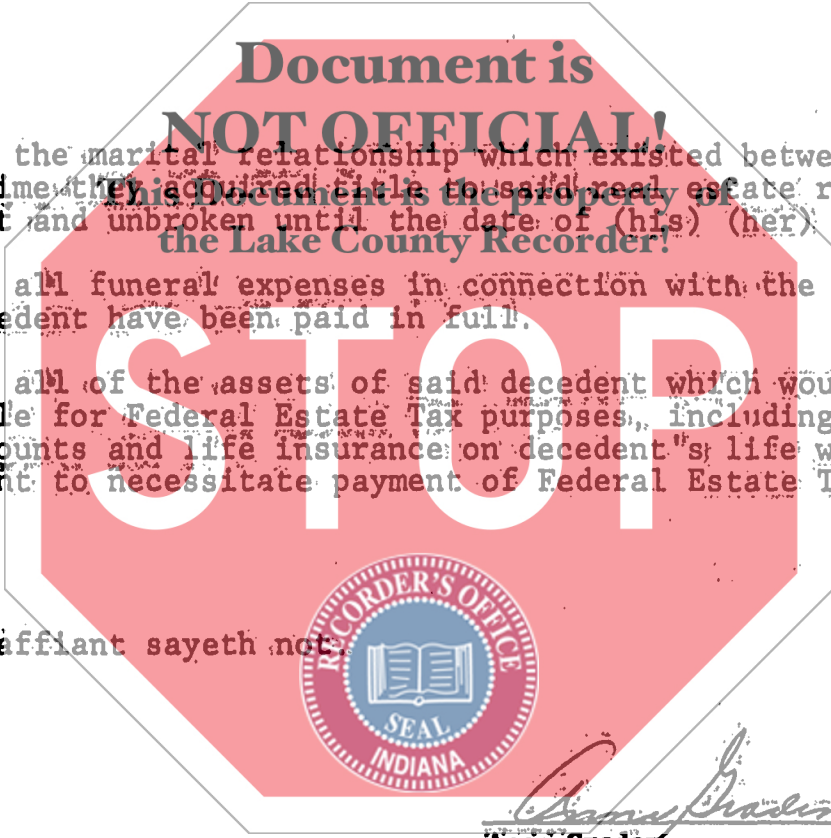
Key # 47-51-25
Lot 24, in Block 4 in L.B. Snowden's Oak Grove Addition to Gary, as per plat thereof, recorded in Plat Book 20 page 10, in the Office of the Recorder of Lake County, Indiana.

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.



Anne Graden
Anne Graden

Subscribed and sworn to before me, a Notary Public, this 19th day of April, 1991.

Barbara J. Hall
Barbara J. Hall Notary Public

My Commission expires:

1-21-95

County of Residence:

Porter

This Instrument prepared by Anne Graden

STATE OF INDIANA/S.S. NO. 1
LAKE COUNTY
FILED FOR REC. 090
MAY 3 10 06 AM '91
ROBERT W. G. FELLEND
RECORDER

FILED

APR 29 1991

Anna M. Anton
AUDITOR LAKE COUNTY

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INDIANA STATE BOARD OF HEALTH

Local No. 1516-90

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) STEPHEN J. GRADEN				2. SEX MALE	3a. TIME OF DEATH 1:08A AM	3b. DATE OF DEATH (Month, Day, Yr) JULY 20, 1990
4. SOCIAL SECURITY NUMBER: 3-15-05-0955	5a. AGE—Last Birthday (Years) 69	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) OCT. 28, 1920	7. BIRTHPLACE (City and State or Foreign Country) SHEPHERD, MICHIGAN	
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: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> X/O/DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				

DECEDENT

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 (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) ANN SZYMANSKI	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) FIRST FURNACE MAN	12b. KIND OF BUSINESS/INDUSTRY U.S. STEEL CORP.

13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION MERRILLVILLE	13d. STREET AND NUMBER 321 WEST 75TH PLACE
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13e. ZIP CODE 46410	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 College (1-4 or 5+)	
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PARENTS

18. FATHER'S NAME (First, Middle, Last) STANLEY GRUDZINSKI	19. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE GOLEMBIEWSKI
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INFORMANT

20a. INFORMANT'S NAME (Type/Print) ANN T. GRADEN	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MERRILLVILLE, IN 46410	20c. Relationship WIFE
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DISPOSITION

21a. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input checked="" 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) JULY 22, 1990 NORTHWEST IN CREMATION SERVICE CROWN POINT, INDIANA	21c. LOCATION—City or Town, State
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22a. EMBALMER'S NAME N/A	22b. EMBALMER'S LICENSE NO. N/A	22c. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
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24a. SIGNATURE OF FUNERAL DIRECTOR: <i>Verence J. Burns</i>	24b. LICENSE NUMBER (of Licensee) 1013890	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME FDH: 8600018 10101 BROADWAY CROWN POINT, IN
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CAUSE OF DEATH

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 asphyxia. Enter only one cause on each line. arrrest due to ventrally fibrillation	Approximate Interval Between Onset and Death 4630-7
IMMEDIATE CAUSE (disease or condition resulting in death) DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.	FILED
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last JULY 23 1990 Celebration accident Hydration	APR 29 1991

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>Charles Johnson</i> LAKE COUNTY HEALTH COMMISSIONER	27. WAS DECEDENT PREGNANT OR 90 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? AUDITOR LAKE COUNTY
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CERTIFIER

29a. CERTIFIER (Check only one) <input 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.

29b. SIGNATURE AND TITLE OF CERTIFIER <i>Verence J. Burns</i>	29c. MEDICAL LICENSE NO. 01030560	29d. DATE SIGNED (Month, Day, Year) 7-20-90
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HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. V. GARLAPATI 6111 HARRISON MERRILLVILLE, INDIANA 46410	31. HEALTH OFFICER'S SIGNATURE <i>Charles Johnson</i>	32. DATE FILED (Month, Day, Year) July 23 1990
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CORONER USE ONLY

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. 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. 0149
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Key # 47-51-25 L.B. Saunders Oak Grove Chh. All L. 24-B.Y.

