457457

Chicago Title Insurance Company

Of 457457 LD (1)

CHICAGO TITLE INSURANCE COMPANY

92012698

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA }
COUNTY OF LAKE } S. S.

On this February 13, 1992 (insert date) before me personally appeared JOHN KERSTEFF

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 the step-son of owner Edmund Lenard a/k/a Edmund J. Lenard & son of owner Helen Lenard (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 EDMUND LENARD a/k/a Edmund J. Lenard and HELEN LENARD;

4. Said EDMUND LENARD a/k/a Edmund J. Lenard and HELEN LENARD (fill in name of co-tenant who died)

died on December 26, 1991 and September 22, 1990, respectively,

leaving a will; (insert "a" or "no" as the case may be)

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

Lot 23, Block "H", Meadowland Manor Unit 2, as shown in Plat Book 31, Page 97, in Lake County, Indiana.

Commonly known as: 5413 Maryland Street, Merrillville, Indiana.

#15-311-23

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;

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:

Not applicable.);

8. Affiant's relationship to the deceased was step-son to Edmund a/k/a Edmund J. Lenard & son to Helen Lenard

Signature: John Kersteff

John Kersteff

Address: 8011 Chapel Dr., Merrillville, Indiana 46410

Subscribed and sworn to before me by the affiant

this February 13, 1992 (insert date)

Pamela L. Bodaner

Notary Public

Pamela L. Bodaner

My Commission Expires April 6, 1994

FILED

FEB 27 1992

Anna N. Antone

AUDITOR LAKE COUNTY

This instrument prepared by Peter L. Benjamin

01398

80 ct

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD

MAR 2 | 19PM '92

ROBERT (BOB) PELAND
RECORDER

INDIANA STATE BOARD OF HEALTH

Local No. 3251-91

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): EDMUND J. LENARD
2. SEX: Male
3a. TIME OF DEATH: 4:55 p M
3b. DATE OF DEATH (Month Day Yr): December 26, 1991
4. SOCIAL SECURITY NUMBER: 313-07-8811
5a. AGE—Last Birthday (Years): 77
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo Day Yr): June 19, 1914
7. BIRTHPLACE (City and State or Foreign Country): New York, New York
8a. WAS DECEDENT A US VETERAN?: no
8b. YEAR LAST SERVED IN US 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. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Widowed
11. SURVIVING SPOUSE (If wife, give maiden name): none
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Operator
12b. KIND OF BUSINESS/INDUSTRY: US Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 5413 Maryland Street
13e. ZIP CODE: 46410
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): 8; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First Middle Last): Lenard
19. MOTHER'S NAME (First Middle Maiden Surname): Anna Hallo

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John Kersteff
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8011 Chapel Drive, Merrillville, IN 46410
20c. Relationship: Stepson

DISPOSITION

21a. METHOD OF DISPOSITION: XX Burial; Cremation; Entombment; Removal from State; Donation; Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): December 30, 1991 Calvary Cemetery
21c. LOCATION—City or Town, State: Portage, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO.: 1042374
23. WAS DEATH REPORTED TO CORONER?: No Yes
24a. SIGNATURE OF FUNERAL DIRECTOR:
24b. LICENSE NUMBER (of Licensee): 1009893
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: PRUZIN BROS. FUNERAL SERVICE #83002453, 6360 Broadway, Merrillville, IN 46410

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. Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiopulmonary arrest

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last:
b. DUE TO (OR AS A CONSEQUENCE OF): Acute lung failure
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

FILED DEC 30 1991 FEB 27 1992

PART II. Other significant conditions contributing to death but not previously stated in Part I

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 OF DEATH? (Yes or no)

CERTIFIER

29a. CERTIFIER (Check only one):
- 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: Milton S. Gasparis
29c. MEDICAL LICENSE NO.: 01037515
29d. DATE SIGNED (Month, Day, Year): December 27, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Milton S. Gasparis M.D., 1356 Lake Park Ave., Hobart, Indiana 46342

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Milton S. Gasparis M.D. Alexander S. Williams, M.D.
32. DATE FILED (Month, Day, Year): December 27, 1991

CORONER USE ONLY

33. MANNER OF DEATH: Natural; Accident; Suicide; Homicide; Pending Investigation; 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 Ooccurred:
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): 01399
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

Mailed Manner #2 RE 23 & H. #15-311-73