

TOKARSKI
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STATE OF INDIANA)
COUNTY OF LAKE) SS:

AFFIDAVIT OF SURVIVORSHIP

Edward M. Trojan, after being duly sworn upon his oath states as follows:

1. That on the 26 day of Feb., 1989 he was duly married to Velma Trojan.

2. During their marriage, they together as husband and wife purchased the following real estate in Lake County, Indiana, more particularly described as:

Lot Thirteen (13) in Block One (1) in Park View Terrace, in the City of Hammond, as per plat thereof recorded in Plat Book 31, Page 60 in the Office of the Recorder of Lake County, Indiana.

3. Velma Trojan died intestate on the 28th day of July, 1991. No estate has been opened for Velma Trojan 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 Velma Trojan's certified death certificate is attached hereto.

4. Edward M. Trojan is the sole heir at law entitled to inherit the above described real estate.

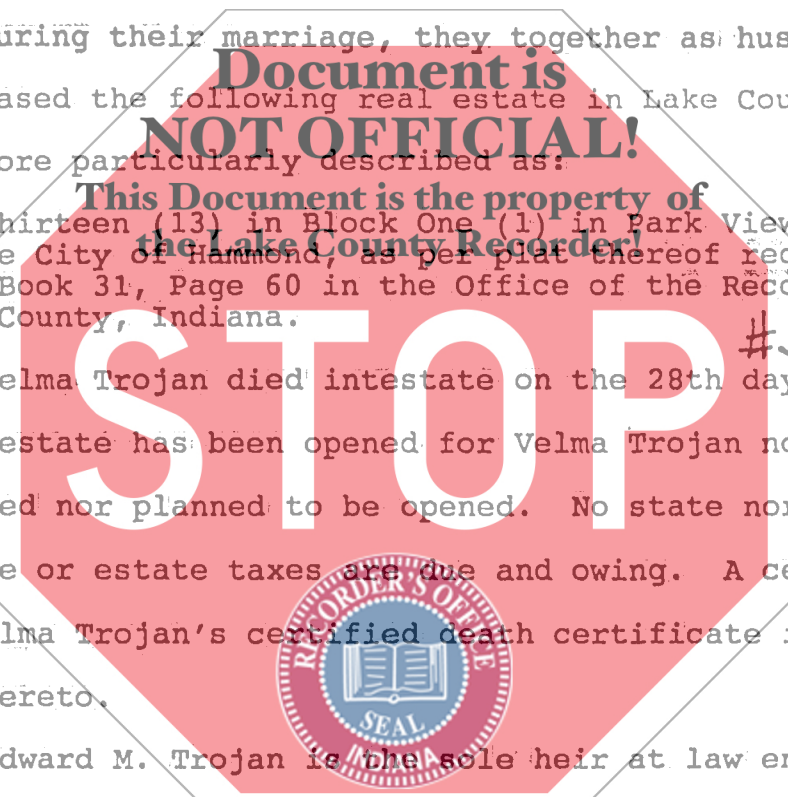
Dated this 26 day of March, 1992.

APR 24 1992

Edward M. Trojan
Edward M. Trojan, Affiant
AUDITOR LAKE COUNTY

STATE OF CALIFORNIA)
COUNTY OF Sonoma) SS:

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



CHICAGO TITLE INSURANCE COMPANY
INDIANA DIVISION

#35-405-13

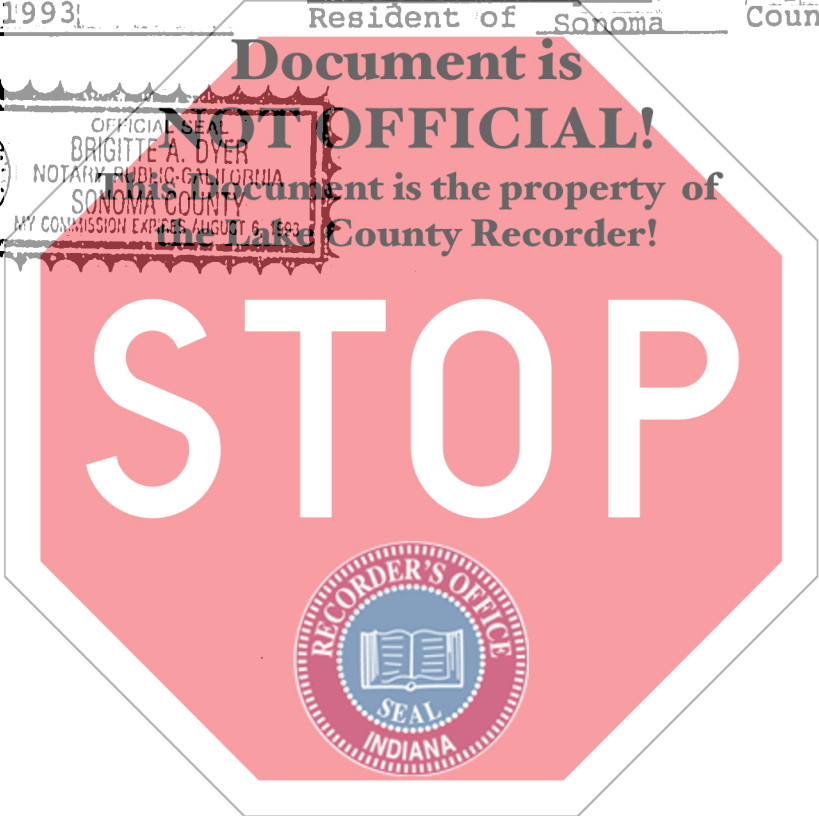
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said County and State, personally appeared Edward M. Trojan, Affiant and acknowledged the execution of said Affidavit of Survivorship to be his voluntary act and deed for the uses and purposes expressed therein.

WITNESS MY HAND AND SEAL, this 26th day of March, 1992.

My Commission Expires: Brigitte A. Dyer
August 6, 1993 Brigitte A. Dyer, Notary Public
Resident of Sonoma County, CA



This Instrument Prepared By: Steve H. Tokarski, 7803 West 75th Avenue, Suite 1, Schererville, IN 46375, 219/769-7214 or 322-1271

INDIANA STATE BOARD OF HEALTH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 584

CERTIFICATE OF DEATH

Date Issued: Aug 1, 1991 *Gregory A. J. Remuda, M.D.*
Hammond Health Commissioner

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) Velma Trojan Female		2 SEX Female	3a TIME OF DEATH 3:57P	3b DATE OF DEATH (Month Day Year) July 28, 1991	
4 SOCIAL SECURITY NUMBER 316-24-9603	5a AGE—Last Birthday (Years) 63	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) FEB 25, 1928	
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana	8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) 7348 Colorado Avenue		9c CITY, TOWN OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Edward M. Trojan	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker		12b KIND OF BUSINESS/INDUSTRY Home	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 7348 Colorado Avenue	
13e ZIP CODE 46323	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 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 (10-12) 12 College (1-4 or 8+)		18 FATHER'S NAME (First Middle Last) Joseph			
19 MOTHER'S NAME (First Middle Maiden Surname) Mary		20a INFORMANT'S NAME (Type/Print) Edward M. Trojan			
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7348 Colorado Ave, Hammond, IN 46323		20c Relationship Husband			
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) JUL 30, 1991 Holy Cross Cemetery		21c LOCATION—City or Town, State Calumet City, Illinois	
22a EMBALMERS NAME Charles D. Scheuer Jr.		22b EMBALMERS LICENSE NO. 1006049		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>John V. Huber</i>		24b LICENSE NUMBER (of Licensee) 1045362		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME 3002869 Virgil Huber Funeral Home 7051 Kennedy, Hammond, IN 46323	
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. a Congestive heart failure b c d				Approximate Interval Between Onset and Death Unknown	
26 PART II: Other significant conditions - Conditions contributing to death but not previously stated in PART I.				27 WAS DECEDENT PREVIOUSLY ADMITTED TO HOSPITAL (Yes or no) No	
28a WAS DECEDENT PERFORMED POSTPARTUM (Yes or no) No				28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) NO	
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 checked="" 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>Daniel D. Thomas</i>			
29c MEDICAL LICENSE NO. 16120		29d DATE SIGNED (Month Day Year) July 31, 1991			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Daniel D. Thomas M.D., 2293 N. Main Street, Crown Point, Indiana 46307					
31. HEALTH OFFICER'S SIGNATURE <i>Gregory A. J. Remuda, M.D.</i>				32 DATE FILED (Month Day Year) Aug 1, 1991	
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <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)			
34g DATE PRONOUNCED DEAD (Month Day Year) July 28, 1991		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

Park View Serv. Rt 13 bl 1, # 35-405-13

STOP

NOT OFFICIAL!

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APR 24 1992

CHICAGO TITLE INSURANCE COMPANY INDIANA DIVISION