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457962 ID

Book of Ngr

92025731

STATE OF INDIANA )  
 ) SS  
COUNTY OF LAKE )

SURVIVORSHIP AFFIDAVIT

Comes now your affiant, Joseph J. Babas, and after being duly sworn upon his oath says as follows:

1. That affiant is the son of Sarah Babas who died at age 87 on December 31, 1989 in Lake County, Indiana.

2. That said Sarah Babas left no Will and affiant was her sole and only heir.

3. That affiant has been a life long resident of the State of Indiana, and, of course, is familiar with all of the business and family affairs of Sarah Babas.

4. The estate of Sarah Babas was not subject to any Indiana Inheritance Tax nor Federal Estate Tax as the entire estate consisted of only a minor interest (which vested in affiant) in the following described real estate:

Key # 27-229-9  
The North 80 feet of the South 645.336 feet of the West 180 feet of Southwest Quarter of the Northeast Quarter of Section 33, Township 36 North, Range 9 West of the 2nd principal meridian, except the West 40 feet, in Lake County, Indiana.

5. That this affidavit is submitted to induce the Chicago Title Insurance Company to issue title insurance policy concerning said described real estate.

6. Your affiant further indemnifies Chicago Title Insurance Company as to any possible claim or cause of action resulting from said Chicago Title Insurance Company relying on this affidavit.

**FILED**

APR 23 1992

*Anna N. Antox*  
AUDITOR LAKE COUNTY

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CHICAGO TITLE INSURANCE COMPANY  
LAKE COUNTY DIVISION

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

APR 27 1 33 PM '92

ROBERT J. O'NEILL  
RECORDER

Further your affiant saith not.

*Joseph J. Babas*  
\_\_\_\_\_  
JOSEPH J. BABAS

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

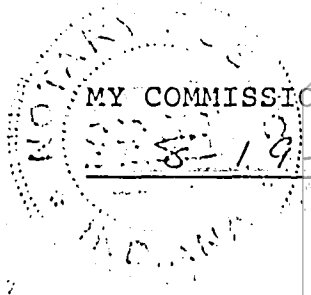
SUBSCRIBED AND SWORN to before me, a Notary Public, in and for said County and State this 20 day of March, 1992

*Thomas C. Granack Sr.*  
\_\_\_\_\_  
THOMAS C. GRANACK, SR.  
NOTARY PUBLIC

This Document is the property of \_\_\_\_\_  
Resident of Lake County, IN  
the Lake County Recorder!

MY COMMISSION EXPIRES:  
5-19-93

**STOP**



INDIANA STATE BOARD OF HEALTH

BANK OF HIGHLAND/MJ  
RE: KEY# 16 27-29-9

Local No. 4979-89

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS  
INFORMANT

DISPOSITION

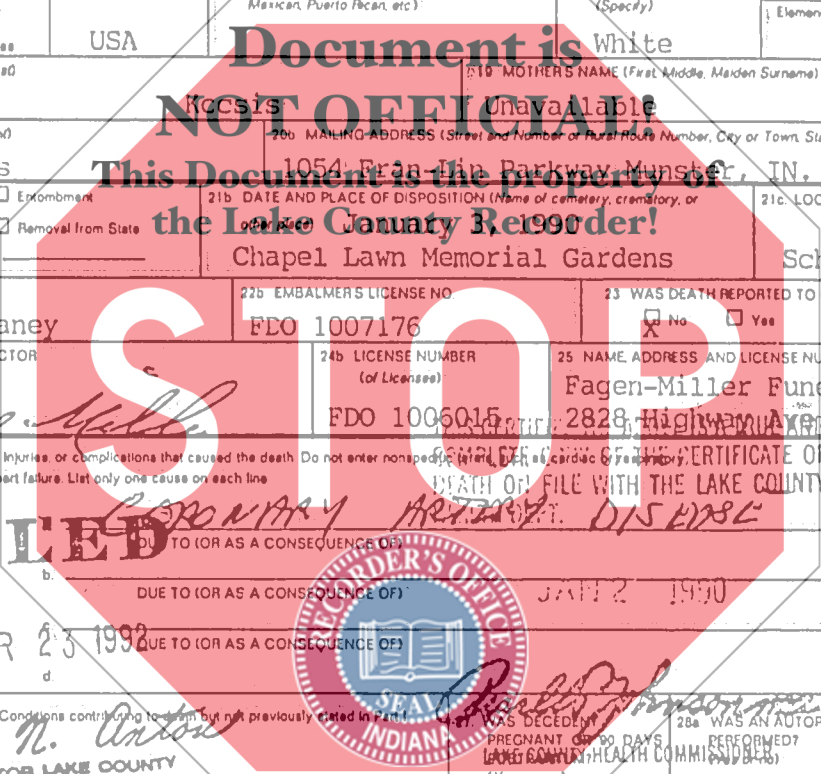
CAUSE OF  
DEATH

CERTIFIER

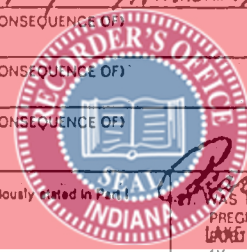
HEALTH  
OFFICER

CORONER  
USE ONLY

1 DECEASED—NAME (First, Middle, Last) Sarah Babas		2 SEX Female	3a TIME OF DEATH 10:30A M	3b DATE OF DEATH (Month, Day, Yr) December 31, 1989	
4 SOCIAL SECURITY NUMBER 316-24-5611	5a AGE—Last Birthday (Year) 87	5b UNDER 1 YEAR Months: Days:	5c UNDER 1 DAY Hours: Minutes:	6 DATE OF BIRTH (Mo, Day, Yr) December 8, 1902	
7 BIRTHPLACE (City and State or Foreign Country) Hungary		8a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES?	9b FACILITY NAME (If not institution give street and number) Towne Centre Health Care Center		9c CITY, TOWN OR LOCATION OF DEATH Merrillville	
9d COUNTY OF DEATH Lake		10 MARITAL STATUS (Specify) Widowed	11 SURVIVING SPOUSE (If wife give maiden name)	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 Own home		13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN, OR LOCATION Munster	
13d STREET AND NUMBER 1054 Fran-Lin Parkway		13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input 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. White	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 8th		
18 FATHER'S NAME (First, Middle, Last) Unavailable		19 MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable			
20a INFORMANT'S NAME (Type/Print) Joseph J. Babas		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1054 Fran-Lin Parkway, Munster, IN, 46321		20c Relationship Son	
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, crematory, or other place) Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Scherverville, Indiana	
22a EMBALMERS NAME Edward F. Mullaney		22b EMBALMER'S LICENSE NO. FEO 1007176	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edward F. Mullaney</i>		24b LICENSE NUMBER (of Licensee) FDO 1006015	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Fagen-Miller Funeral Gardens Inc 2828 Highway 140N Highland, Indiana 46321		
26 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as "cardiac" or "cerebral." (List only one cause on each line.) IMMEDIATE CAUSE (Final disease or condition resulting in death) b. DUE TO (OR AS A CONSEQUENCE OF) c. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last d. DUE TO (OR AS A CONSEQUENCE OF)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. <i>Anna N. Anton</i> AUDITOR LAKE COUNTY		27 WAS DECEDENT PREGNANT OR 90 DAYS BEFORE COUNTY HEALTH COMMISSIONER (Yes or no) No		28a WAS AN AUTOPSY PERFORMED? 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"/> 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>Paul E. Pruitt</i>		29c MEDICAL LICENSE NO. 15267	29d DATE SIGNED (Month, Day, Year) JAN 2, 1990		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <i>Paul E. Pruitt, no 775 Promontory, Merrillville IN 46410</i>					
31 HEALTH OFFICER'S SIGNATURE <i>Paul Johnson</i>			32 DATE FILED (Month, Day, Year) 1-2-90		
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 JAN
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.			



**FILED**  
APR 23 1990



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