

92035357



# TICOR TITLE INSURANCE

## AFFIDAVIT

STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

ROBERT  
RECORDED  
HIGHLAND

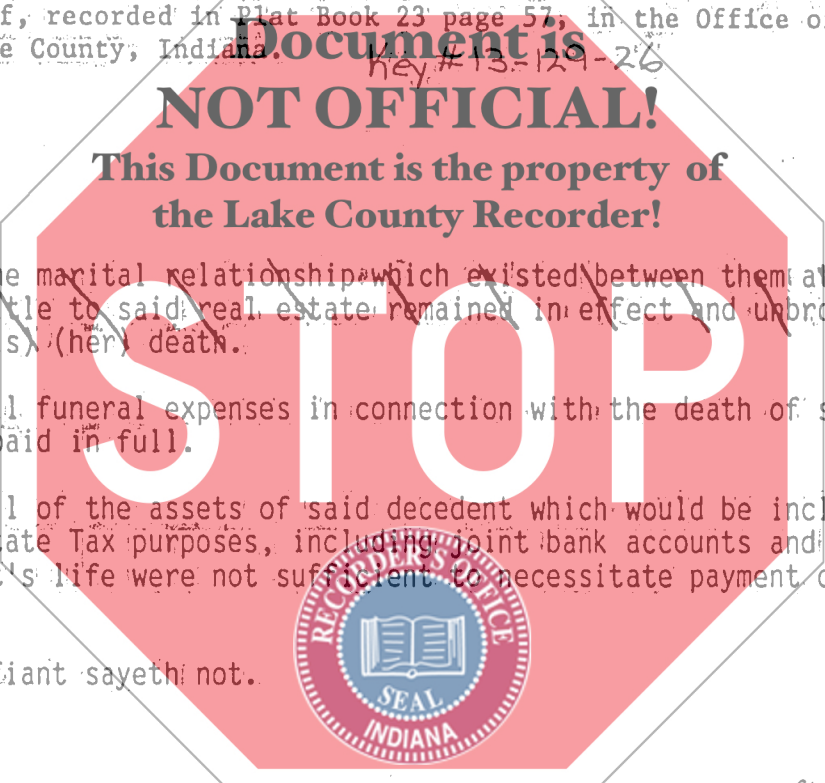
JUN 3 9 26 AM '92

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

Helen Saurborne, being first duly sworn upon oath, deposes and says:

1. That Michael N. Sacek died on July 20, 1991 at \_\_\_\_\_.

2. That Michael N. Sacek and Helen Saurborne were ~~were~~ duly and legally married at the time they acquired title as husband and wife to the following described real estate: Brother and Sister, Lot 26, in Lincoln Parkway Acres, in the Town of Schererville, as per plat thereof, recorded in Plat Book 23 page 57, 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.

Helen Saurborne

Helen Saurborne 20th day of

Subscribed and sworn to before me, a Notary Public, this \_\_\_\_\_ day of \_\_\_\_\_, 1992.



Linda S. Wood  
Linda S. Wood Notary Public

My Commission expires:  
10-17-94

MAY 29 1992

County of Residence: Anna N. Anton  
Lake  
AUDITOR LAKE COUNTY

This Instrument prepared by Helen Saurborne

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Lincoln Parkway Acres L.26 Key #13-129-26; unit #20

INDIANA STATE BOARD OF HEALTH

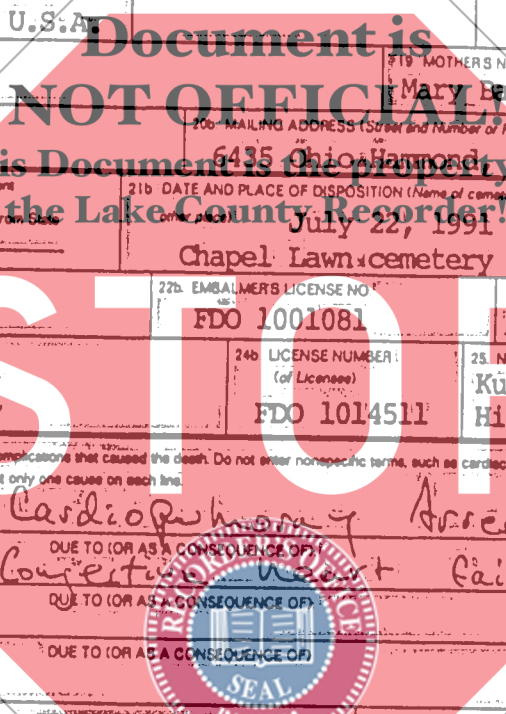
Local No. 1492-91

CERTIFICATE OF DEATH

State No.

TYPE/PRINT IN PERMANENT BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>Michael N. Sacek</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>1:45 A.M.</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>July 20, 1991</b>
4. SOCIAL SECURITY NUMBER <b>306-03-2046</b>	5a. AGE—Last Birthday (Years) <b>80</b>	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) <b>Sep. 10, 1910</b>
7a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>	7b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Mossena, Pa.</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Dyer</b>		9c. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Widowed</b>	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) <b>First Helper</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Steel Co.</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>Crown Point</b>	13d. STREET AND NUMBER <b>7501 W. 77th Ave.</b>	
13e. ZIP CODE <b>46307</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (10-12): <b>UNK</b> College (1-4 or 5+): <b>UNK</b>		18. FATHER'S NAME (First, Middle, Last) <b>Andrew Sacek, Sr.</b>		
19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Baron</b>		20a. INFORMANT'S NAME (Type/Print) <b>Helen Saubornier</b>		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6435 Ohio, Hammond, Indiana</b>		20c. Relationship <b>Sister</b>		
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) <b>July 22, 1991 Chapel Lawn cemetery</b>		21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>
22a. EMBALMERS NAME <b>Ronald A. Reed</b>		22b. EMBALMERS LICENSE NO. <b>FDO 1001081</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO 1014511</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500</b>	
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. <b>a. Cardiopulmonary Arrest</b> <b>b. Congestive Heart Failure</b>				
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Cardiopulmonary Arrest</b>				
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last. <b>CONGESTIVE HEART FAILURE</b>				
PART II Other significant conditions: Conditions contributing to death but not previously listed in Part I.				
THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT.				
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		<b>NO</b>		
29a. 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 DECEASED <i>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>01038216</b>	29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Alber to R. Sanchez 1326 W. U.S. Rt. 30 Schererville, IN 46375</b>				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) <b>July 23, 1991</b>		
33. MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide				
34a. DATE OF INJURY (Month, Day, Year)		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. 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**  
**MAY 29 1992**



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