

92052335

SURVIVORSHIP AFFIDAVIT

COMMUNITY TITLE CO. FILE NO. L4994

STATE OF Indiana §  
COUNTY OF Lake § S.S.

On this July 23, 1992 before me personally appeared,  
(insert date)

Theresa J. Zimmerman

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 Daughter owner  
(state interest of affiant in the above premises as owner)
3. Said premises described as follows: Lot 35 in Block 8 in County Club Estates Subdivision, in the City of Hobart, as per plat thereof, Recorded December 13, 1926 in Plat Book 20 page 41, in the office of the Recorder of Lake County, Indiana.

Reg # 17-87 35

4. Said premises were formerly owned as ~~joint tenants or~~ as tenants by the entireties by William L. Dziadosz and Dorothy T. Dziadosz

5. Said William L. Dziadosz (fill in name of co-tenant who died) died on April 28, 1992

leaving 9 will:  
(insert "a" or "no")

6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? no  
(If answer is "yes", identify the divorce proceedings:)

7. Affiant's relationship to the deceased was daughter

**FILED**

AUG 11 1992

Ann R. Anton  
AUDITOR LAKE COUNTY

Affiant's Signature Theresa J. Zimmerman

Name Printed Theresa J. Zimmerman

Address 8414 King William Street  
Cordova, TN. 38018

Subscribed and sworn before me by the affiant  
this July 23, 1992  
(insert date)

Patricia Ludington  
(Notary Public)

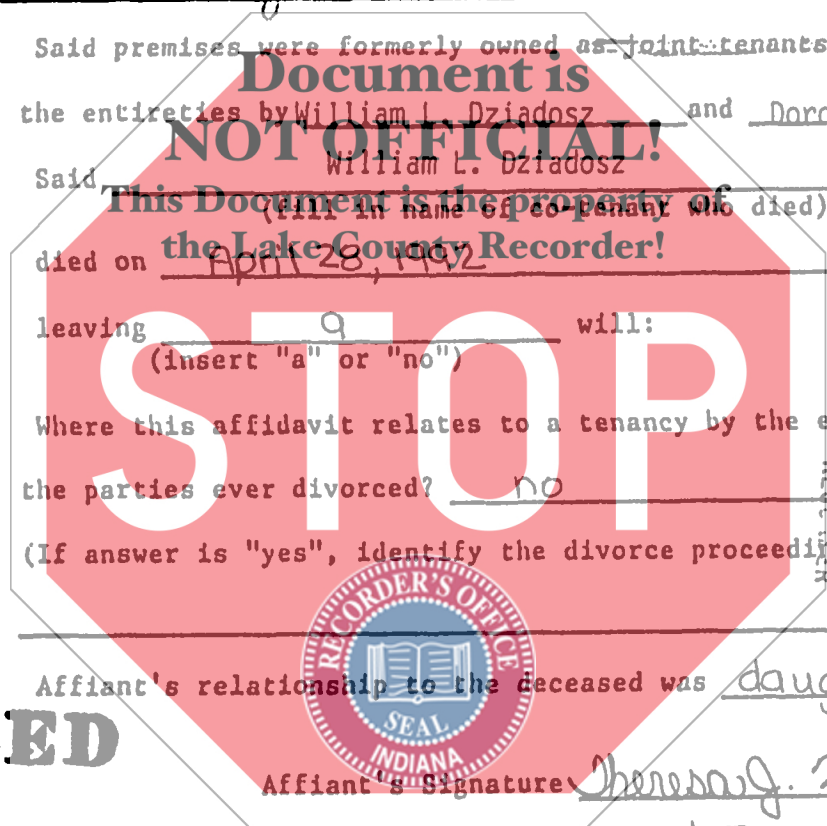
Patricia Ludington Lake County, Indiana  
(printed name and county)

My commission expires 04-15-94

This instrument prepared by: Theresa J. Zimmerman

00081

SCM



STATE OF INDIANA, S.S. NO. FILED FOR RECORD  
AUG 17 11 07 AM '92  
ROBERT H. REED, RECORDER, LAKE COUNTY, INDIANA

INDIANA STATE BOARD OF HEALTH

7 Reg.  
2 Vets  
9 Total

Local No. ... 0972-92 ...

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) <b>WILLIAM L. DZIADOSZ</b>		2 SEX <b>MALE</b>	3a TIME OF DEATH <b>3:04 P M</b>	3b DATE OF DEATH (Month Day Yr) <b>APRIL 28, 1992</b>
4 SOCIAL SECURITY NUMBER <b>314-14-8897</b>	5a AGE—Last Birthday (Years) <b>70</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>MARCH 26, 1922</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>GARY, INDIANA</b>	8a WAS DECEDENT A U.S. VETERAN? <b>YES</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	

DECEDENT

9a FACILITY NAME (If not institution, give street and number) <b>ST. MARY MEDICAL CENTER</b>	9c CITY, TOWN, OR LOCATION OF DEATH <b>HOBART</b>	9d COUNTY OF DEATH <b>LAKE COUNTY</b>
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PARENTS

10. MARITAL STATUS (Specify) <b>MARRIED</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>DOROTHY T. LASKOWSKI</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>SUPERVISOR</b>	12b. KIND OF BUSINESS/INDUSTRY <b>U.S. STEEL SHEET &amp; TIN MILL</b>
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INFORMANT

13a. RESIDENCE—STATE <b>INDIANA</b>	13b. COUNTY <b>LAKE</b>	13c. CITY, TOWN, OR LOCATION <b>HOBART</b>	13d. STREET AND NUMBER <b>132 N. DELAWARE STREET</b>
13e. ZIP CODE <b>46342</b>	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? <b>USA</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 (0-12) <b>12</b> College (1-4 or 5 +)		

DISPOSITION

18. FATHER'S NAME (First Middle Last) <b>GEORGE DZIADOSZ</b>	19. MOTHER'S NAME (First Middle Maiden Surname) <b>MARY PIEKUT</b>	
20a. INFORMANT'S NAME (Type/Print) <b>TERRY ZIMMERMAN</b>	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8861 WINDING HOLLOW WAY, SPRINGFIELD, VA 22152</b>	20c. Relationship <b>DAUGHTER</b>

CAUSE OF DEATH

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>CALVARY CEMETERY</b>	21c. LOCATION—City or Town, State <b>PORTAGE, INDIANA</b>
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CAUSE OF DEATH

22a. EMBALMER'S NAME <b>JAMES W. GHOLSTON</b>	22b. EMBALMER'S LICENSE NO. <b>FDO1004194</b>	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>	24b. LICENSE NUMBER (of Licensee) <b>FDO1006463</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>REES FUNERAL HOMES, INC. FH83003069 600 W. RIDGE RD, HOBART, IN 46342</b>

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 heart failure. List only one cause on each line.

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT MYOCARDIAL INFARCTION

IMMEDIATE CAUSE OF DEATH: **Acute Myocardial Infarction**

HEALTH DEPT. FILE WITH THE LAKE COUNTY HEALTH DEPT.

Conditions, if any, which give rise to the immediate cause, stating the underlying cause last: **Diabetes Mellitus**

MAY 07 1992

Approximate Interval Between Onset and Death

CAUSE OF DEATH

PART II. Other significant conditions - Conditions contributing to death but not previously stated (if any)			27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>N/A</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>N/A</b>
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CERTIFIER

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.
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CERTIFIER

29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rodolfo L. Jao, MD</i>	29c. MEDICAL LICENSE NO. <b>01026118</b>	29d. DATE SIGNED (Month, Day, Year) <b>4-30-92</b>
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HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>RODOLFO L. JAO, MD, 1400 S. LAKE PARK AVENUE, HOBART, IN 46342</b>	31. HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>	32. DATE FILED (Month, Day, Year) <b>May 1, 1992</b>
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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"/> Could not be Determined <input type="checkbox"/> Homicide	34a. DATE OF INJURY (Month, Day, Year) <b>AUG 11 1992</b>	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no) <b>AUG 11 1992</b>	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) <i>Area N. Union</i> <b>INDIAN LAKE COUNTY</b>			

34g. DATE PRONOUNCED DEAD (Month, Day, Year)	34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc <b>00082</b>
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