COMMUNITY TITLE COMPANY

— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

L 5699

93013708

AFFIDAVIT L-5699

MAR 2 12 36 PM '93
SAMUEL OLIGH
RECORDER

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

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JAMES R. KOBYLANSKI, being first duly sworn upon oath, deposes and says:

1. That Affiant's ~~spouse~~ FATHER VICTOR S. KOBYLANSKI died (without leaving a will) (leaving a will) on OCTOBER 3, 1990 ~~19--~~ at James R. Kobylanski 341 N. MONTGOMERY ST, GARY, IN

2. That VICTOR S. KOBYLANSKI AND VIRGINIA L. KOBYLANSKI ~~xxxx~~ were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

THE SOUTH 65 FEET OF LOT 423 IN ROBERT BARTLETT'S MARQUETTE PARK ESTATES FIRST ADDITION, IN THE CITY OF GARY, AS PER PLAT THEREOF, RECORDED JULY 30, 1947 IN PLAT BOOK 27 PAGE 57, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

4H 35422

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) ~~xxxx~~ 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.

FEB 19 1993

Further affiant sayeth not.

Dana N. Untos
AUDITOR LAKE COUNTY

James R. Kobylanski
JAMES S. KOBYLANSKI

Subscribed and sworn to before me, a Notary Public, this 5th day of February, 19 93.

Loretta J. Gottschling
Loretta J. Gottschling Notary Public

My Commission expires:
04-07-96

County of Residence:

Lake

This Instrument prepared by JAMES S. KOBYLANSKI

00766

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CM

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 90-0699 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Victor Stanley Kobylanski
2. SEX: Male
3a. TIME OF DEATH: 2:36 A.M.
3b. DATE OF DEATH (Month, Day, Yr): October 3, 1990
4. SOCIAL SECURITY NUMBER: 311-10-7171
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo, Day, Yr): Nov. 30, 1908
7. BIRTHPLACE (City and State or Foreign Country): Milwaukee, Wisconsin
8a. WAS DECEDENT A U.S. VETERAN?: Yes
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: 1945
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 341 North Montgomery Street
9c. CITY, TOWN OR LOCATION OF DEATH: Gary
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): Truck Driver-Elect. Dept.
12b. KIND OF BUSINESS/INDUSTRY: Steel - US Steel Works - Gary
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN OR LOCATION: Gary
13d. STREET AND NUMBER: 341 North Montgomery Street
13e. ZIP CODE: 46403
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ 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): 12; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Idzi Fausten
19. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Wojda

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Virginia Lustgarten
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6460 Old Porter Rd., Portage, IN 46368
20c. Relationship: Daughter

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): October 4, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Henry Blake
22b. EMBALMER'S LICENSE NO: FD01019406
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Barbara M. Lail
24b. LICENSE NUMBER (of Licensee): FD0101 2674
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Lach Funeral Home FH83002526, 6121 Miller Avenue, Gary, IN 46403

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Vascular collapse.
DUE TO (OR AS A CONSEQUENCE OF):
b. Due to arteriosclerotic heart and vascular disease.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

Approximate Interval Between Onset and Death: Unknown

PART II. Other significant conditions. 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): 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: Daniel D. Thomas M.D. C.C.
29c. MEDICAL LICENSE NO.: 16120
29d. DATE SIGNED (Month, Day, Year): October 4, 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Rebecca L Foston MD MPH
32. DATE FILED (Month, Day, Year): OCT. 4 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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):
FEB 19 1993
34g. DATE PRONOUNCED DEAD (Month, Day, Year): October 3, 1990
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: Driver N. Anton

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1