

93017728

ESTATE AFFIDAVIT

RE: FA- 8X8X 8018

Address: 4620 Johnson Street Gary

Legal Description: Lots 4, 5 and 6, Block 6 in L.B. Snowden's Oak Grove Addition to Gary, as per plat thereof, Recorded in Plat Book 20 page 10, in the Office of the Recorder of Lake County Indiana

FILED

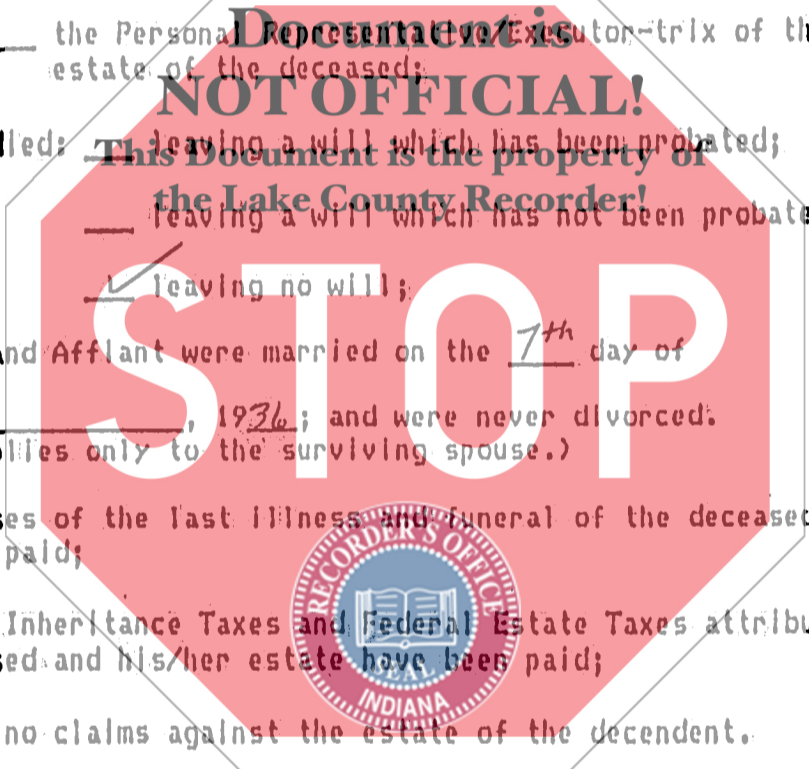
MAR 17 1993

Andrea N. Anton
AUDITOR LAKE COUNTY

RETURN TO:
FIRST AMERICAN TITLE INS. CO.
6235 COMMERCE DR. SUITE 1
CROWN POINT, IN 46307

Minnie E Stevens, Affiant, states that:

- George Stevens, deceased, died on the 6th day of July, 1991
- Affiant is: the surviving spouse of the deceased;
 the Personal Representative/Executor-trix of the estate of the deceased;
- The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;
- The deceased and Affiant were married on the 7th day of JUNE, 1936; and were never divorced.
(This item applies only to the surviving spouse.)
- All expenses of the last illness and funeral of the deceased have been paid;
- All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;
- There are no claims against the estate of the decedent.



STATE OF INDIANA, S.S. NO. 1
LAKE COUNTY
FILED FOR RECORD
MAR 22 11 32 AM '93
SAMUEL L. LICH
RECORDER

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

March 5 1993
Date

Minnie E Stevens
Signature of Affiant

Minnie E Stevens
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 5th day of March, 1993.

Andrea A Plasencia
Printed Name of Notary

Andrea A Plasencia
Signature of Notary

My Commission expires: 9-17-93
My County of Residence is: Lake

Prepared By: Minnie E Stevens

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fa

THIS DOCUMENT NOT VALID UNLESS STAMPED ON REVERSE SIDE

PORTER COUNTY BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

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) George Stevens		2 SEX Male	3a TIME OF DEATH 8:15pm	3b DATE OF DEATH (Month Day Year) July 6, 1991	
4 SOCIAL SECURITY NUMBER 317-09-5519	5a AGE—Last Birthday (Years) 80	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) June 30, 1911	
7a WAS DECEDENT A US VETERAN? Yes	7b YEAR LAST SERVED IN US ARMED FORCES? 1944	8 PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) Porter Memorial		9b CITY, TOWN, OR LOCATION OF DEATH Valparaiso	9c COUNTY OF DEATH Porter		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Minnie E. Erbesti	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Owner/Operator	12b KIND OF BUSINESS/INDUSTRY Painting/Decorating		
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Gary	13d STREET AND NUMBER 4620 Johnson		
13e ZIP CODE 46408	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) White	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) 10		18 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (11-4 or 8+)			
19 FATHER'S NAME (First Middle Last) Alex. Stevanov		19b MOTHER'S NAME (First Middle Maiden Surname) Rakajla Stevanov			
20a INFORMANT'S NAME (Type/Print) Minnie E. Stevens		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620 Johnson Gary, IN. 46408	20c Relationship Wife		
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 (City or Town, Cemetery, or other place) July 10, 1991 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME David Semplinski		22b EMBALMER'S LICENSE NO. FD08600686	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert Wiatrolak</i>		24b LICENSE NUMBER (of Licensee) FD01001293	24c NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Stilnovich & Wiatrolak FH3004455 7535 Taft Merrillville, IN. 46410		
25 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA		25 PART II: Other significant conditions - Conditions contributing to death, but not previously stated in Part I		Approximate Interval Between Onset and Death 1 month	
IMMEDIATE CAUSE (Final disease or condition resulting in death)		DUE TO (OR AS A CONSEQUENCE OF)		MAR 17 1993 INDIANA MORTON LAKE COUNTY	
Conditions, if any, which give rise to the immediate cause, stating the underlying cause last		DUE TO (OR AS A CONSEQUENCE OF)			
		DUE TO (OR AS A CONSEQUENCE OF)			
26a 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.		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	
29a SIGNATURE AND TITLE OF CERTIFIER <i>A. H. ...</i>		29b MEDICAL LICENSE NO. 0180830	29c DATE SIGNED (Month Day Year) 7/9/91		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) Dr. Abey 6040 Luge Rd. Portage, IN. 46368 219-763-2606					
31 HEALTH OFFICER'S SIGNATURE <i>David R. ... MD</i>		32 DATE FILED (Month Day Year) July 9, 1991			
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 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)		34h MOTOR VEHICLE ACCIDENT? (Yes or no)—If yes specify driver, passenger, pedestrian etc		00768	

