

Please Return to:
Citizens Federal Svcs.
1720 45th. Ave
Munster, In. 46321

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

2

MAR 26 1 22 PM '93
SARAH L. CALLECH
RECORDER

Chicago Title Insurance Company
STATE LAKE COUNTY
FILED FOR RECORD

93018957 SURVIVORSHIP AFFIDAVIT

JULIA EMRICK, being first duly sworn upon oath, deposes
and says:

1. That she is the surviving wife of Michael Emrick,
Jr., who died in Lake County, Indiana on the 10th day of January,
1993.

2. That she and the said Michael Emrick were husband
and wife when they, as tenants by the entireties, became owners of
the following real estate, to-wit:

Lot 3, Fairmeadow Seventh Addition, Block 1,
to the Town of Munster, as shown in Plat Book
40, page 106, in Lake County, Indiana.

and remained husband and wife continuously thereafter until the
death of said Michael Emrick, Jr., at which time she became the
sole owner of the above real estate.

3. That the Estate of Michael Emrick, Jr. was not
subject to Federal Estate Tax.

4. That Affiant makes this affidavit for the purpose
of having the above real estate transferred to her name on the tax
records.

Subscribed and sworn to before me this 12th day of
March, 1993.



Julia Emrick

JULIA EMRICK

Faye Cowser

Faye Cowser
Notary Public

My Commission Expires: 9/9/93
9/9/93

County of Residence:
Lake

FILED
MAR 27 1993
Arns N. Antos
AUCTIONEER LAKE COUNTY

This Instrument Prepared By: John E. Chevigny, Galvin, Galvin &
Leeney, 5231 Hohman Avenue, Hammond, IN 46320

800pb
ct

01184

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0070-93

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

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) Michael Emrick		2 SEX Male	3a TIME OF DEATH 4:57 A.M.	3b DATE OF DEATH (Month Day, Yr) January 10, 1993
4 SOCIAL SECURITY NUMBER 306-01-6367	5a AGE—Last Birthday (Years) 75	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) May 30, 1917
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? -	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> <input type="checkbox"/> ERI/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 9212 Chestnut Lane		9c CITY TOWN OR LOCATION OF DEATH Munster		9d COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Julia Misecko	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Superintendent Pattern Shop		12b KIND OF BUSINESS/INDUSTRY Tank Car Manufacture
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Munster	13d STREET AND NUMBER 9212 Chestnut Lane	
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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. (Specify) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5)		18 FATHER'S NAME (First Middle, Last) Michael Emrick, Sr.		
19 MOTHER'S NAME (First Middle Maiden Surname) Katherine Slampyak		20a INFORMANT'S NAME (Type/Print) Julia Emrick		
20b MAKING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9212 Chestnut Ln, Munster, IN 46321		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State		21b DATE AND PLACE OF DISPOSITION (Specify cemetery, crematory, or other place) January 12, 1993 Resurrection Cemetery		21c LOCATION—City or Town, State Hammond, Indiana
22a EMBALMER'S NAME Larry D. Anthony		22b EMBALMER'S LICENSE NO. 01001447		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		24b LICENSE NUMBER (of Licensee) 01001447		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dzialowicz F.H. 83002916 9445 Calumet Ave, Munster, IN 46321
26 PART I: Enter the disease, injury, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory failure, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Metastatic prostatic carcinoma DUE TO (OR AS A CONSEQUENCE OF) Metastatic prostatic carcinoma DUE TO (OR AS A CONSEQUENCE OF) Metastatic prostatic carcinoma DUE TO (OR AS A CONSEQUENCE OF) Metastatic prostatic carcinoma				Approximate Interval Between Onset and Death 5 weeks 2 1/2 years
PART II: Other significant conditions contributing to death but not previously stated in Part I. ① Metastatic squamous carcinoma of the brain ② Recurrent aspiration pneumonia				27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) N/A.
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) 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>Alexander Milione (Zajac)</i>			29c MEDICAL LICENSE NO. 01040122	29d DATE SIGNED (Month, Day, Year) January 11, 1993
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Andrej Zajac, M.D., 901 MacArthur Boulevard, Munster, Indiana 46321				
31. HEALTH OFFICER'S SIGNATURE <i>Alexander Milione, MD</i>				32 DATE FILED (Month Day, Year) January 12, 1993
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.		01182		



Form 774 added to Munster
 28-313-3
 James 774 added to Munster

Chicago Title Insurance Company