

7/7/58 Djukic+Vane

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TICOR TITLE INSURANCE
Highland, Indiana

TICOR TITLE INSURANCE

93041281

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

ODILIA M. PAVNICK
sworn upon oath, deposited and says:

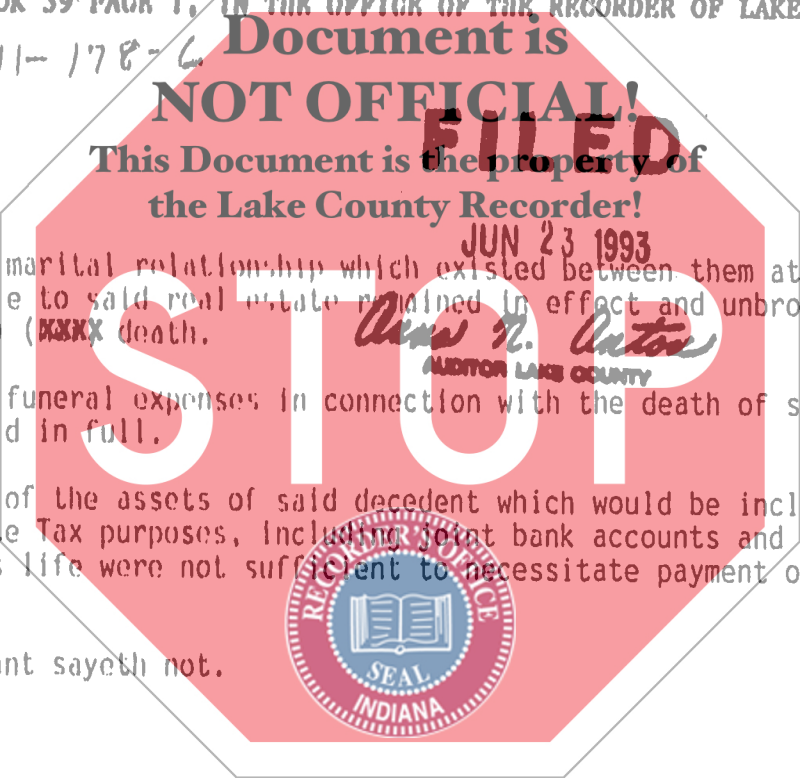
1. That LOUIS R. PAVNICK
Dec 20

being first husband of Odilia M. Pavnick, died Dec 20 1992 at St. Margaret Mercy - South

2. That LOUIS R. PAVNICK and ODILIA M. PAVNICK were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 6 IN BAKER'S ROLLING HILLS ADDITION, UNIT 1, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 39 PAGE 1, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

K# 9-11-178-6



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.

Further affiant sayeth not.

Odilia M. Pavnick
ODILIA M. PAVNICK

Subscribed and sworn to before me, a Notary Public, this 9TH day of JUNE, 19 93.

Jean Henderson
Notary Public
JEAN HENDERSON

My Commission expires: 12-3-93

County of Residence: LAKE

This Instrument prepared by ODILIA M. PAVNICK

00915800
pi

6-14-93

177158 Djukic & Jona

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

Local No. 2663-92

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

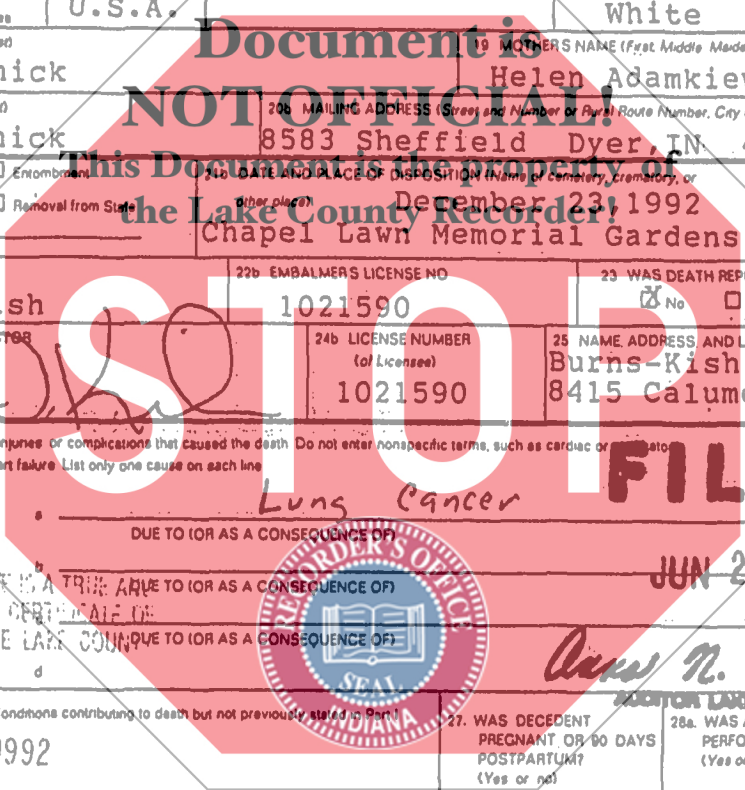
CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1 DECEASED—NAME (First, Middle, Last) Louis Robert Pavnick				2 SEX Male	3a TIME OF DEATH 2:50A.M.	3b DATE OF DEATH (Month, Day, Yr) December 20, 1992	
4 SOCIAL SECURITY NUMBER 1340-30-7929		5a AGE—Last Birthday (Years) 54	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) Sept. 14, 1938		
8a WAS DECEDENT A U.S. VETERAN? Yes		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1959		9a PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy - South			9c CITY, TOWN OR LOCATION OF DEATH Dyer		9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Odilia Vespo		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Supervisor		12b KIND OF BUSINESS/INDUSTRY Commonwealth Edison.	
13a RESIDENCE—STATE IN.		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Dyer		13d STREET AND NUMBER 8583 Sheffield	
13e ZIP CODE 46311	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) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		18 FATHER'S NAME (First, Middle, Last) Robert Pavnick					
19 MOTHER'S NAME (First, Middle, Maiden Surname) Helen Adamkiewicz		20e INFORMANT'S NAME (Type/Print) Odilia Pavnick					
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8583 Sheffield Dyer, IN 46311		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"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 23, 1992 Chapel Lawn Memorial Gardens		21c LOCATION—City or Town, State Schererville, IN			
22a EMBALMER'S NAME Kevin W. Kish		22b EMBALMER'S LICENSE NO. 1021590		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) 1021590		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321			
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. Lung Cancer						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) Lung Cancer						FILED	
DUE TO (OR AS A CONSEQUENCE OF) JUN 23 1993							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I DEC 23 1992							
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. CERTIFIER (Type/Print) Robert M. Drasga To the best of my knowledge death occurred at the time, date, and place and due to the cause(s) as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> HEALTH OFFICER							
29c. MEDICAL LICENSE NO. 1031484							
29d. DATE SIGNED (Month, Day, Year) Dec. 23, 1992							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) R.E. Drasga, M.D. 9725 Prairie Highland, IN 46322							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>							
32. DATE FILED (Month, Day, Year) December 23, 1992							
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.					



Barbera Rolling Ato-Add
 #1
 #79-11-176-6

TICOR TITLE INSURANCE
 Highland, Indiana

00916
6-14-93