



TICOR TITLE INSURANCE

93049499

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JUL 30 9 48 AM '93
SARAH WILSON
RECORDER

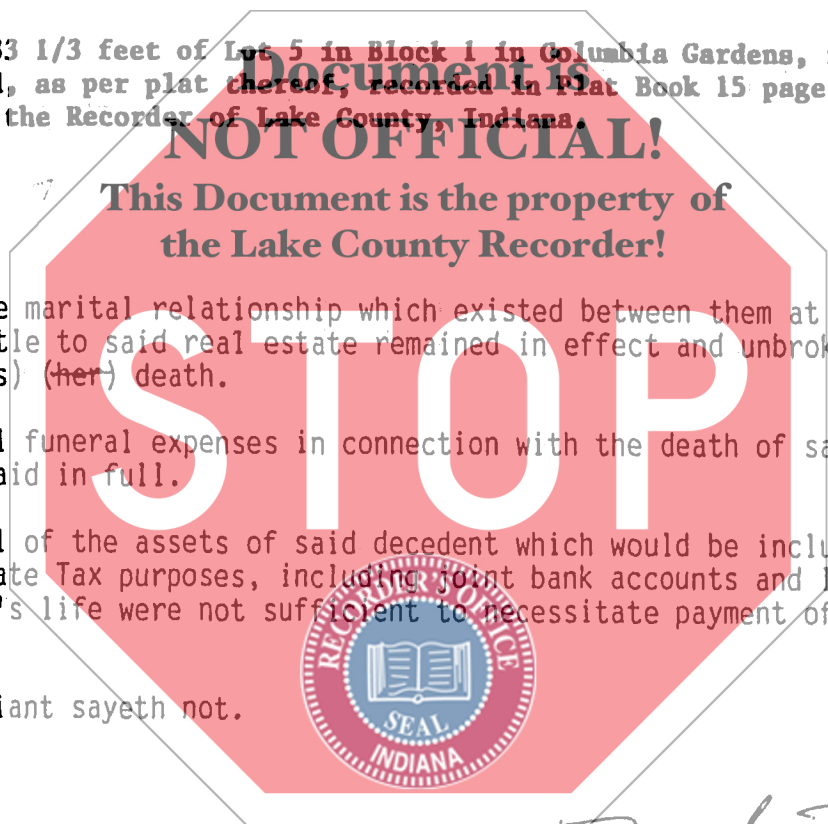
TICOR TITLE INSURANCE
COUNTY OF LAKE
FILED FOR RECORD

Frank Tuskan, being first and last name of affiant,
sworn upon oath, deposes and says:

1. That Thomas Tuskan died on February 12, 1966 at Hammond, Ind.

2. That Thomas Tuskan and Sophie Tuka were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

The East 33 1/3 feet of Lot 5 in Block 1 in Columbia Gardens, in the City of Hammond, as per plat thereof, recorded in Plat Book 15 page 2, in the Office of the Recorder of Lake County, Indiana.



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) (her) 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.

Frank Tuskan
Frank Tuskan

Subscribed and sworn to before me, a Notary Public, this 12th day of July, 1993.

FILED

JUL 28 1993

Jean Henderson
Jean Henderson Notary Public

My Commission expires Anna N. Anton
12-3-93
AUDITOR LAKE COUNTY

County of Residence:
Lake

This Instrument prepared by Frank Tuskan

00683

800
8-75

178999 Bg Highland
Tract 13-4034

INDIANA STATE BOARD OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL CERTIFICATE OF DEATH

State No. _____

TYPE OR PRINT
PLAINLY WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

Local No. 133

789 Highland, Indiana
TOPR TITLE INSURANCE

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>LAKE</u> | | 3. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>INDIANA</u> b. COUNTY <u>LAKE</u> | |
| b. CITY, TOWN, OR LOCATION <u>HAMMOND</u> | | c. CITY, TOWN, OR LOCATION <u>HAMMOND</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST MARGARET HOSPITAL</u> | | d. STREET ADDRESS <u>1018-167 ST</u> | |
| e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 7. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS (Tom) TUSKAN</u> | | 4. DATE OF DEATH Month Day Year <u>2 12 - 66</u> | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | |
| 8. DATE OF BIRTH <u>12-15-1899</u> | | 9. AGE (In years, last birthday) <u>66</u> | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 11. BIRTH PLACE (State or foreign country) <u>YUGO SLAVIA</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED BY IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17a. INFORMANT'S NAME <u>Sophie Tuskan</u> | | 17b. RELATIONSHIP TO DECEASED <u>Wife</u> | |
| 17c. INFORMANT'S ADDRESS <u>1018-167 St Hammond Ind</u> | | 17d. RELATIONSHIP TO DECEASED <u>Wife</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO (b) <u>Pneumonitis</u> DUE TO (c) <u>Reperfusion of lungs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR INJURY GIVEN IN PART I (a), (b), and (c). | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in Part II of Item 18.) <u>JUL 20 1993</u> | |
| 20c. TIME OF INJURY Hour Month Day Year a. m. p. m. | | 20d. PLACE OF INJURY (If a, b, or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | |
| 20e. CITY, TOWN, OR LOCATION <u>HAMMOND INDIANA</u> | | 20f. STATE <u>INDIANA</u> | |
| 21. ATTENDING PHYSICIAN: I certify that I attended the deceased from <u>2/17/66</u> to <u>2/17/66</u> and last saw him alive on <u>2/17/66</u> Death occurred at <u>8:05 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | 22. HEALTH OFFICER: I certify that I investigated cause of death of deceased and find that death occurred at _____ M <input type="checkbox"/> E.B.T. <input type="checkbox"/> C.R.T. from causes stated and on above date. | |
| 22a. Signature of Attending Physician or Health Officer. <u>[Signature]</u> M.D. | | 22b. ADDRESS <u>6134 Columbia Ave</u> | |
| 22c. DATE SIGNED <u>2/14/66</u> | | 22d. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>2-16-66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN</u> | | 23d. LOCATION <u>HAMMOND IND</u> | |
| DATE REC'D BY LOCAL HEALTH OFFICER <u>FEB 18 1966</u> | | SIGNATURE OF HEALTH OFFICER <u>[Signature]</u> | |
| 25. FUNERAL DIRECTOR <u>MARYSLIVY FUNERAL HOME HAM'D IND</u> | | ADDRESS | |

Columbia Gardens
k 33 131 k 5 k 1

DEALER'S NAME Joseph M. Gagnier
LICENSE NO. 81411
FUNERAL DIRECTOR'S LICENSE NO. 559

1-8900
Disposition Permit Issued / /
Provisional Certificate Yes No

