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# TICOR TITLE INSURANCE

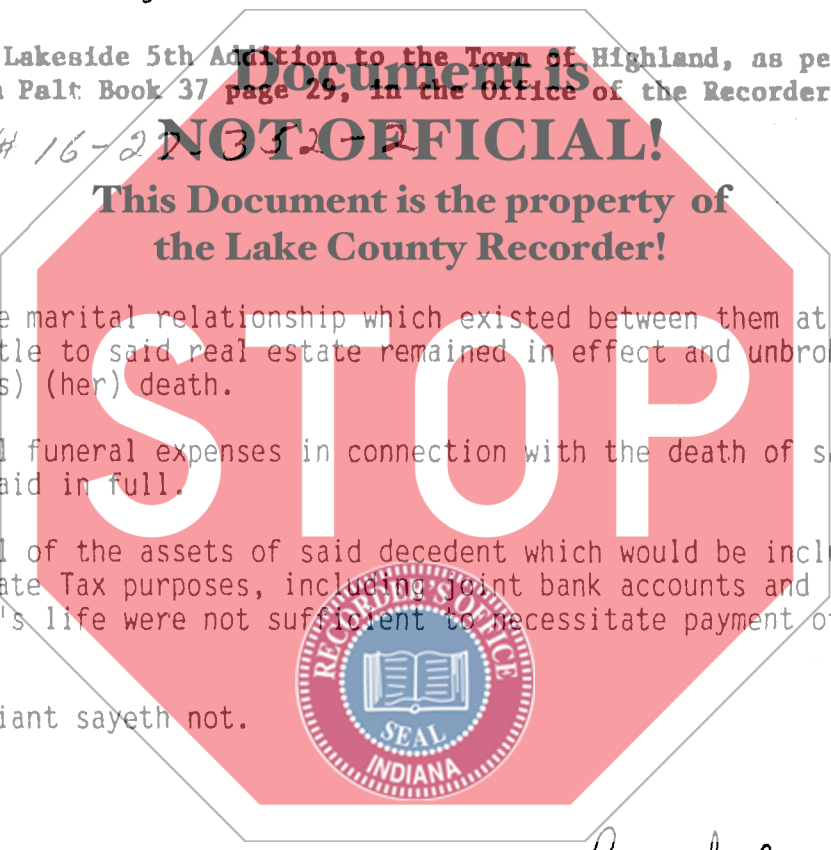
## AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Gayle I. Marcus, being first duly sworn upon oath, deposes and says:

1. That Nick Marcus, Jr. died on May 9, 1990 at St. Margaret Hosp. HAMMOND, IN.
2. That Nick Marcus Jr and Gay I. Marcus were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 129 in Lakeside 5th Addition to the Town of Highland, as per plat thereof, recorded in Plat Book 37 page 29, 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.

Gayle I. Marcus  
Gayle I. Marcus

Subscribed and sworn to before me, a Notary Public, this 30th day of July, 1993.

# FILED

AUG 4 1993

Jean Henderson  
Jean Henderson Notary Public

My Commission expires:  
12-3-93

County of Residence:  
Lake

This Instrument prepared by Gayle I. Marcus

00252

800  
TW  
8-4-93

179021  
Kelley

INDIANA STATE BOARD OF HEALTH  
Highland, Indiana  
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

MAY 17, 1990  
Date Issued *Franklin S. O. Remuda, M.D.*  
Hammond Health Commissioner

Local No. 410

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

179021

27-352-2 Lakeside 54 added 8.12.9 #44 16-27-352-2

1. DECEASED—NAME (First, Middle, Last) <b>Nick Marcus Jr.</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>2:20 a.m.</b>	3b. DATE OF DEATH (Month, Day, Year) <b>May 9, 1990</b>	
4. SOCIAL SECURITY NUMBER <b>317-14-7726</b>	5a. AGE—Last Birthday (Year) <b>68</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month, Day, Year) <b>Mar. 4, 1922</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>N/A</b>				
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		8c. PLACE OF DEATH (Check only one. See instructions)			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Margaret Hospital</b>		9b. CITY, TOWN, OR LOCATION OF DEATH <b>Hammond</b>		9c. COUNTY OF DEATH <b>Lake</b>	
10. MARRITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Gayle Hammond</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired). <b>Engineer</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Highland</b>		13d. STREET AND NUMBER <b>3127 99th St. E.</b>	
14a. ZIP CODE <b>46322</b>	14b. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	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) <b>White</b>	
17. DECEDENT'S EDUCATION (Specify only highest grade completed)		18. DECEDENT'S EDUCATION (Specify only highest grade completed)			
Elementary/Secondary (9-12)		College (1-4 or more)			
19. FATHER'S NAME (First, Middle, Last) <b>Nicholas Marcus, Sr.</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Pustina</b>			
20a. INFORMANT'S NAME (Type/Print) <b>Gayle Marcus</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3127 99th St. E. Highland, Indiana 46322</b>		20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Chapel Lawn Cemetery</b>		21c. LOCATION—City or Town, State <b>Schererville, Indiana</b>	
22a. EMBALMER'S NAME <b>Ronald A. Reed</b>		22b. EMBALMER'S LICENSE NO. <b>FDO 1001081</b>	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) <b>FDO 1014511</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500</b>		
26. PART I. Enter the disease, 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) <b>acute non-lymphocytic leukemia</b>					
DUE TO (OR AS A CONSEQUENCE OF)					
CONDITIONS, if any, which gave rise to the immediate cause, stating the underlying cause last					
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) <b>NO</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
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>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>33507</b>	29d. DATE SIGNED (Month, Day, Year) <b>May 9, 1990</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>H. Mishoulam, M.D. 9725 Prairie Avenue, Highland, Indiana 46322</b>					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) <b>MAY 10 1990</b>		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.			



TICOR TITLE INSURANCE  
Crown Point, Indiana

(Copy)