

Chicago Tide Insurance Company

SATISFACTION OF MORTGAGE

93056745

This Certifies, That a certain Mortgage executed by ROLAND RINDOKS AND LILLIAN H. RINDOKS, HUSBAND AND WIFE

..... GERALDINE J. SOPCZAK

Document is

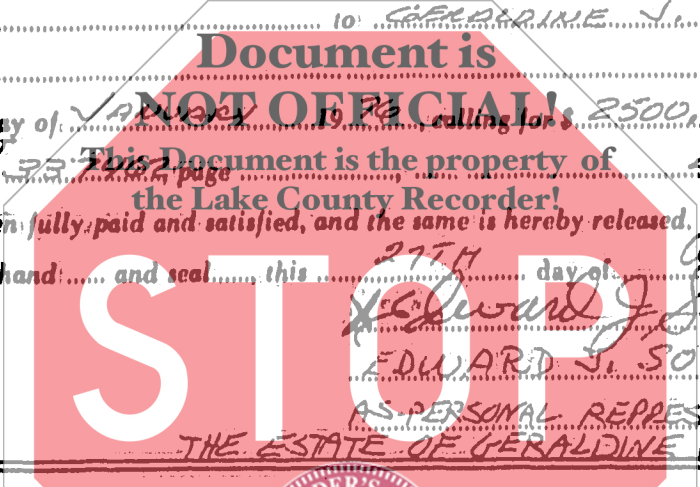
NOT OFFICIAL!

on 27th day of JANUARY, 1993, calling for \$ 2500.00 and recorded

in Mortgage ~~Number~~ No. 22 This Document is the property of LAKE County,

State of Indiana, has been fully paid and satisfied, and the same is hereby released.

WITNESS my hand and seal this 27th day of August, 1993



Edward J. Sopczak
EDWARD J. SOPCZAK
AS PERSONAL REPRESENTATIVE OF
THE ESTATE OF GERALDINE J. SOPCZAK

State of Indiana, LAKE County, ss:

Before me the undersigned a Notary Public in and for said County, this 27th

day of AUGUST, 1993,

AS PERSONAL REPRESENTATIVE OF EDWARD J. SOPCZAK
OF GERALDINE J. SOPCZAK

acknowledged the execution of the annexed satisfaction of mortgage.

Witness my Hand and official seal.

Victoria Caldwell

VICTORIA CALDWELL Notary Public.
Res. of Lake Co.

My Commission expires 10/05/96

This instrument prepared by:
ROLAND RINDOKS

20 feet thereof; block 2, University Gardens, in the city of Hammond, as shown in plat book 29, page 42, in Lake County, Indiana.

007

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 0719-92

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) GERALDINE SOPCZAK				2 SEX FEMALE	3a TIME OF DEATH 7:06 AM	3b DATE OF DEATH (Month Day Yr) MARCH 29, 1992	
4 SOCIAL SECURITY NUMBER 305-90-9193		5a AGE—Last Birthday (Years) 61	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) OCT. 12, 1930		7 BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO, INDIANA
8a WAS DECEDENT A US VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE		9a PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <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) THE COMMUNITY HOSPITAL	
10 MARRITAL STATUS (Specify) MARRIED				11 SURVIVING SPOUSE (if wife, give maiden name) EDWARD SOPCZAK		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Assistant Vice President	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION EAST CHICAGO		13d STREET AND NUMBER 4131 DRUMMOND ST.	
13e ZIP CODE 46312		14 CITIZEN OF WHAT COUNTRY? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16 RACE—American Indian, Black, White, etc. (Specify) WHITE	
17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5+) 2		18 FATHER'S NAME (First Middle Last) PETER HINDOXS		19 MOTHER'S NAME (First Middle Maiden Surname) ANNA SIMON		20a INFORMANT'S NAME (Type/Print) EDWARD J. SOPCZAK	
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip) 46312		20c Relationship HUSBAND		21a METHOD OF DISPOSITION (Check only one) <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 (Name of cemetery, crematory, or other place) APRIL 1, 1992 HOLY CROSS CEMETERY	
22a EMBALMER'S NAME HENRY BLAKE		22b EMBALMER'S LICENSE NO. FDO 1019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		24 SIGNATURE OF FUNERAL DIRECTOR <i>Raymond Prusiecki</i>	
24b LICENSE NUMBER (of Licensee) FDO1039517		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Prusiecki Funeral Home, Inc. FDH3001562 P. O. Box J, East Chicago, Indiana 46312		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. a Small bowel obstruction b Metastatic adenocarcinoma c Adenocarcinoma of left of ovary, widely metastatic		26b DATE OF DEATH APRIL 1, 1992	
26 PART II: Other significant conditions contributing to death but not previously stated on Part I. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.		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 (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. 38489		29d DATE SIGNED (Month, Day, Year) MARCH 30, 1992	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. ABIODUN SOLOLA, M.D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>				32 DATE FILED (Month, Day, Year) March 31, 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"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month, Day, Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
34d PLACE OF INJURY—At home (stn, street, factory, office, building, etc.) (Specify)		34e DESCRIBE HOW INJURY OCCURRED					
34f DATE PRONOUNCED DEAD (Month, Day, Year)		34g MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					



22, 14, etc. N 20 + 21, etc. S 20, 8L 2m University, Harding, Hammond, PB 29 Pg 42, LC, I.