ADDRESS: 114 Plum CreekDr.,Unit 1N
Schererville, IN 46375

FILED

NOV 30 1993

Auditor Lake County

93080600

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

On the 12th day of November, 19 93, before me personally appeared ROSE ANGELOU, to me personally known, who being duly sworn on oath, did say that:

1. Affiant resides at 114 Plum Creek Dr., Unit 1 N Schererville, Indiana.

2. Affiant is the owner of the following described property located in Lake County, Indiana: Unit 1 North, 114 Plum Creek Drive, Schererville, Indiana and Garage Space 2 North in Plot Plan, Lot 3, as per plat thereof, recorded in Plat Book 50, page 80, in Plum Creek No. III, IV and V, a Horizontal Property Regime, as per Declaration recorded June 20, 1979, as Document No. 535471 and corrected by certificate of correction recorded October 30, 1979 as Document No. 557397, in Office of the Recorder of Lake County, Indinaa. Together with an undivided 1/12th interest in the common areas appertaining thereto.

3. Said premises were formerly owned as tenants by the entireties by ANGELO N. ANGELOU and ROSE ANGELOU husband and wife.

4. Said ANGELO N. ANGELOU died on the 18th day of March, 19 90, leaving no will.

5. That to the best of the Affiant's knowledge, there is no estate or inheritance tax liability by reason of the death of said decednet; and all funeral expenses and expenses of last illness have been paid in full.

6. That Affiant and ANGELO N. ANGELOU were never divorced and Affiant is the surviving spouse of said decedent.

Rose Angelou
ROSE ANGELOU

SUBSCRIBED and SWORN to before me, by the Affiant, on this 12 day of November, 19 93.

My Commission Expires:
3/20/96

Judith A. Osinski
JUDITH A. OSINSKI, Notary Public
Resident of LAKE County.

1114

THIS INSTRUMENT PREPARED BY:
THOMAS L. KIRSCH, Attorney at Law
131 Ridge Road, Munster, IN 46321
219-836-1384

8.00

STATE OF INDIANA S.S.
LAKE COUNTY FILED FOR RECORD
Dec 2 9 10 AM '93

Local No. 678-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
ANGELO N. ANGELOU	MALE	7:50 PM	MARCH 18, 1990

4. SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
333-09-2018	75			JANUARY 30, 1915	FALL RIVER, MASS

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
N/A		HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
114 PLUM CREEK DR. APT 1 N	SCHERERVILLE	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
MARRIED	ROSE DERVENIS	MILKMAN	DIXIE DAIRY

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
INDIANA	LAKE	SCHERERVILLE	114 PLUM CREEK DR APT 1 N

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46375	☐ No ☒ Yes	☒ No ☐ Yes	USA	☐ No ☐ Yes	WHITE	Elementary/Secondary (0-12): 12	College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
NICK ANGELOU	HELEN KOUZA

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
ROSE ANGELOU	114 PLUM CREEK DR SCHERERVILLE IN 46375	WIFE

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Entombment ☐ Donation ☐ Other (Specify)	MARCH 21, 1990 ELMWOOD CEMETERY	HAMMOND, INDIANA

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
DANIEL BURNS	1007558	☐ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Thomas J. Burns	1045184	BURNS-KISH FUNERAL HOMES 3004968 8415 CALUMET AVE MUNSTER IN 46321

CAUSE OF DEATH

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. anaplastic myelomia — Approximate Interval Between Onset and Death: 1 yr
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

FILED MAR 21 1990

CERTIFIER

29a. CERTIFIER (Check only one): ☐ CERTIFYING PHYSICIAN ☐ HEALTH OFFICER ☐ CORONER

To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

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.

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.

THIS CERTIFIES THAT I HAVE COMPLETED AND FILED THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
COMPLETE CAUSE OF DEATH ON FILE WITH LAKE COUNTY HEALTH DEPT.	01036259	March 21, 90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
DR. GLEATON, 7905 CALUMET AVE MUNSTER, INDIANA 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
MAR 21 1990 Paul H. Johnson MD	

CORONER USE ONLY

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.
	N/A

SBH06-004 State Form 10110 (R2/3-89) DEA CERT-PD I