185002

TICOR-MERRILLVILLE

TICOR TITLE INSURANCE

94026564

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

JOHN O. CHIABAI AND ROGER A. CHIABAI, being first duly sworn upon oath, deposes and says:

1. That REGINA CHIABAI died on June 15, 19 90 at Hobart, Indiana.

2. That REGINA CHIABAI and OLIVER J. CHIABAI were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 14 IN BLOCK 6 IN KELLEY-GLOVER-VALE PARKSIDE ADDITION TO GARY, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 18 PAGE 2, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA; COMMONLY KNOWN AS 3681 FILLMORE ST., GARY, INDIANA 46408.

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.

25-45-193-101

JOHN O. CHIABAI

ROGER A. CHIABAI

Subscribed and sworn to before me, a Notary Public, this 1st day of APRIL, 1994.

FILED

APR 7 1994

PAULA BARRICK Notary Public

My Commission expires:

10/02/97

County of Residence:

LAKE

This Instrument prepared by JOHN O. CHIABAI

00374

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

APR 8 10 08 AM '94

SARAH CHURCH
RECORDER

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 1293-90 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Regina M. Chiabai
2. SEX: Female
3a. TIME OF DEATH: 2:00 P. M
3b. DATE OF DEATH (Month, Day, Yr.): June 15, 1990
4. SOCIAL SECURITY NUMBER: 312-05-5260 B
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): August 10,1913
7. BIRTHPLACE (City and State or Foreign Country): Dubuque, Iowa
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? ---
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): St. Mary Medical Center
9c. CITY, TOWN, OR LOCATION OF DEATH: Hobart
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Oliver J. Chiabai
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
12b. KIND OF BUSINESS/INDUSTRY: Own Home
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Gary
13d. STREET AND NUMBER: 3681 Fillmore Street
13e. ZIP CODE: 46408
13f. INSIDE CITY LIMITS ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Nicholas Campbell
19. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Grue

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Oliver J. Chiabai
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3681 Fillmore Street, Gary, Indiana 46408
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☒ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): June 19, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana
22a. EMBALMER'S NAME: Dennis LaPine
22b. EMBALMER'S LICENSE NO.: FD008700141
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Ronald J. Mesarch
24b. LICENSE NUMBER (of Licensee): FD01005912
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Geisen Funeral Home, Inc. FH83007762, 7905 Broadway, Merrillville, In. 46410

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. Cerebral Infarction

DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerosis

DUE TO (OR AS A CONSEQUENCE OF): c.

Conditions, if any, which gave rise to the immediate cause stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death: a. b. c. d.

FILED

APR 7 1994

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

PART II. Other significant conditions - Conditions contributing to death but not previously listed in Part I.

JUN 19 1990

27. WAS DECEDENT PREGNANT OR WITHIN 90 DAYS OF DELIVERY/ABORTION/MISCARRIAGE? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): Yes
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): Yes

CERTIFIER

29a. CERTIFIER (Check only one): ☒ CERTIFYING PHYSICIAN ☐ MEDICAL EXAMINER ☐ CORONER
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) 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) 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.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul A. Johnson M.D. LAKE COUNTY HEALTH COMMISSIONER
29c. MEDICAL LICENSE NO.: 17087
29d. DATE SIGNED (Month, Day, Year): 6-19-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): John G. Kolettis, M.D., 6111 Harrison Street, Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Paul A. Johnson M.D.
32. DATE FILED (Month, Day, Year): June 19, 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

00375

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1