



TICOR TITLE INSURANCE

94026565

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

APR 8 10 08 AM '94
SARAH LITCH
RECORDER

STATE OF INDIANA, S.S.M.D.
LAKE COUNTY
FILED FOR RECORD

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

1. That OLIVER J. CHIABAI died on May 18, 1993 at Merrillville, Indiana.

2. That OLIVER J. CHIABAI and REGINA 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.

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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.

John O. Chiabai
JOHN O. CHIABAI
Roger A. Chiabai
ROGER A. CHIABAI

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

FILED

APR 7 1994

Anna M. Anton

Paula Barrick
PAULA BARRICK Notary Public

My Commission expires:

10/02/97

County of Residence:

LAKE

This Instrument prepared by JOHN O. CHIABAI

00376

Handwritten initials

25-45 199 14

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1060-93

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

**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) OLIVER J. CHIABAI		2 SEX Male	3a TIME OF DEATH 10:58 P.M.	3b DATE OF DEATH (Month Day, Yr) May 18, 1993
4 SOCIAL SECURITY NUMBER 312-05-5266A	5a AGE—Last Birthday (Years) 82	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day, Yr) April 11, 1911
7 BIRTHPLACE (City and State or Foreign Country) Chicago, Illinois	8a WAS DECEDENT A U.S. VETERAN? No			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? --	8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)			
9a FACILITY NAME (If not institution give street and number) Methodist Hospital - Southlake Campus		9b CITY TOWN OR LOCATION OF DEATH Merrillville		9c COUNTY OF DEATH Lake
10 MARITAL STATUS (Specify) Widowed	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) Construction		12b KIND OF BUSINESS/INDUSTRY Carpenter
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Gary	13d STREET AND NUMBER 3681 Fillmore	
13e ZIP CODE 46408	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) White
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		17 College (1-4 or 5 +)		
18 FATHER'S NAME (First Middle Last) John Chiabai		19 MOTHER'S NAME (First Middle, Maiden Surname) Mary Krucil		
20a INFORMANT'S NAME (Type/Print) Roger Chiabai		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6743 VanBuren Ct., Merrillville, IN 46410		20c Relationship Son
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) May 21, 1993 Calumet Park Mausoleum		21c LOCATION—City or Town, State Merrillville, Indiana
22a EMBALMER'S NAME Charles W. Wells		22b EMBALMER'S LICENSE NO. 1042372		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>John A. Pruzin</i>		24b LICENSE NUMBER (of Licensee) 1007231		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410
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) a. Respiratory Failure with Right Pneumonia DUE TO (OR AS A CONSEQUENCE OF) b. Congestive Cardiac Failure with Dysrhythmia DUE TO (OR AS A CONSEQUENCE OF) c. Chronic Renal Failure with Metabolic Acidosis DUE TO (OR AS A CONSEQUENCE OF) d. PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I Diabetes Mellitus				Approximate Interval Between Onset and Death
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)
29. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature] MD</i>				
29a MEDICAL LICENSE NO. 01029954		29b DATE SIGNED (Month, Day, Year) 5.19.93		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Alvin S. [Signature] M.D., 8300 Broadway, Merrillville, IN 46410 (219) 769-5800				
31. HEALTH OFFICER'S SIGNATURE <i>Alvin S. [Signature] M.D.</i>				32. DATE FILED (Month, Day, Year) May 20, 1993
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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		FILED		
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) APR 7 1994		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. 00377		