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TICOR TITLE INSURANCE

FILED

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APR 20 1994

Anna M. Anton
AUDITOR LAKE COUNTY

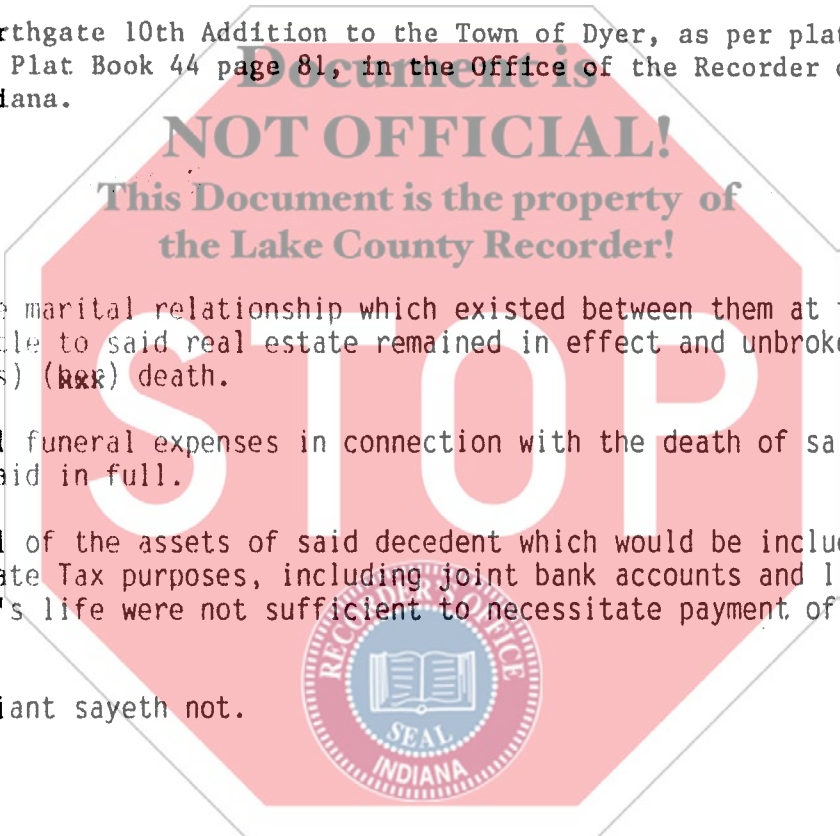
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Susan M. Malek, being first duly sworn upon oath, deposes and says:

1. That Glenn W. Malek died on September 19, 1991 at Dyer, Ind.

2. That Glenn W. Malek and Susan M. Malek were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 3 in Northgate 10th Addition to the Town of Dyer, as per plat thereof, recorded in Plat Book 44 page 81, 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.

Susan M. Malek
Susan M. Malek

Subscribed and sworn to before me, a Notary Public, this 11th day of April, 1994.

Jean Henderson
Jean Henderson Notary Public

My Commission expires:

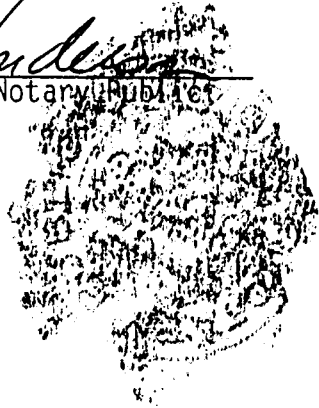
12-3-97

County of Residence:

Lake

This Instrument prepared by Susan M. Malek

STATE OF INDIANA
LAKE COUNTY
FILED APR 20 1994
APR 21 10 15 AM '94
S.A. RECORDER JH



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01251

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1940-91

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) Glenn W. Malek				2 SEX Male	3a TIME OF DEATH 9:30 A.M.	3b DATE OF DEATH (Month, Day, Yr.) September 19, 1991
4 SOCIAL SECURITY NUMBER 333-42-1245		5a AGE—Last Birthday (Years) 36	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr.) March 13, 1955	7 BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana
8a WAS DECEDENT A US VETERAN? No	8b YEAR LAST SERVED IN US ARMED FORCES? -	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) XX Residence				
9b FACILITY NAME (If not institution give street and number) 1045 Madison Avenue			9c CITY, TOWN OR LOCATION OF DEATH Dyer		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife give maiden name) Susan Ferry		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Serviceman		12b KIND OF BUSINESS/INDUSTRY Bottling Company
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Dyer		13d STREET AND NUMBER 1045 Madison Avenue
13e ZIP CODE 46311	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) 12						
18 FATHER'S NAME (First, Middle, Last) Frank Malek				19 MOTHER'S NAME (First, Middle, Maiden Surname) Irene Meduga		
20a INFORMANT'S NAME (Type, Print) Susan Malek			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1045 Madison Ave., Dyer, IN 46311		20c Relationship Wife	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) Sept. 19, 1991 Opyt Funeral Home Chicago, Illinois Sept. 21, 1991 Holy Cross Cemetery Calumet City, Illinois		21c LOCATION—City or Town, State	
22a EMBALMER'S NAME N/A			22b EMBALMER'S LICENSE NO. N/A		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Henry D. Anthony</i>			24b LICENSE NUMBER (of Licensee) 01001447		25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz F.H. 83002916 9445 Calumet Ave, Munster, IN 46321	
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 (First disease or condition resulting in death) a. METASTATIC MELANOMA DUE TO (OR AS A CONSEQUENCE OF) b. MELANOMA OF LEFT ABDOMEN DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ PART II: Other significant conditions. Conditions contributing to death but not previously stated in Part I.						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) 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>Cal Streeter</i>				29c MEDICAL LICENSE NO. 543		29d DATE SIGNED (Month, Day, Year) September 21, 1991
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) Calvin Streeter, D.O. 9635 Saric Drive, Highland, IN 46322						
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams MD</i>						32 DATE FILED (Month, Day, Year) Sept 23, 1991
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.			

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