STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

95 JAN -9 AM 8:56

AMASA G. COLBY
CHIEF DEP. RECORDER

SURVIVORSHIP AFFIDAVIT

95001393

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

On this 29th day of December, 1994, before me personally appeared CORINNE M. KUZOS, to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature.

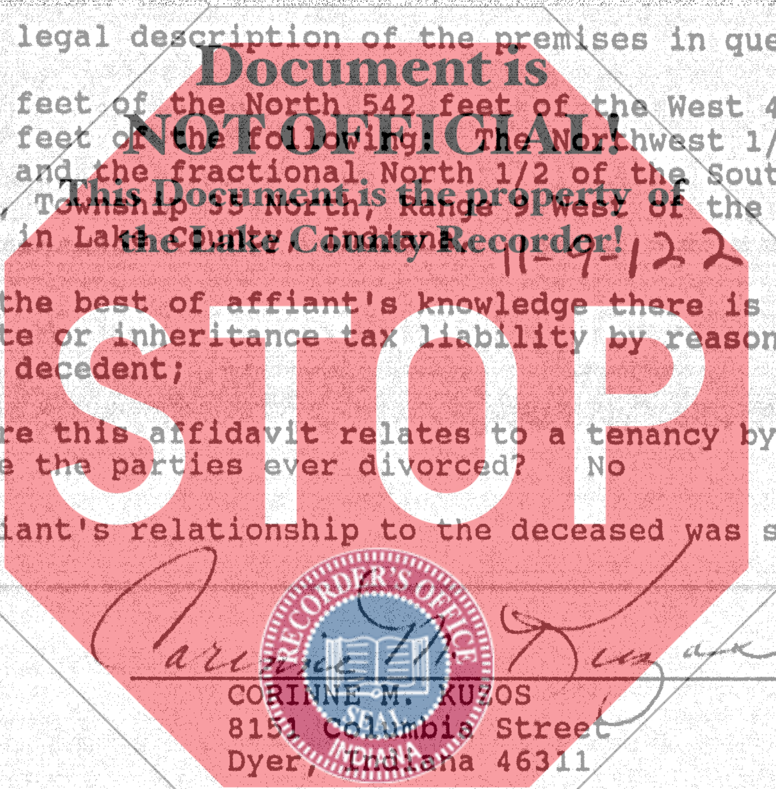
2. Affiant is the co-tenant by entireties.

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Raymond R. Kuzos and Corinne M. Kuzos.

4. Said Raymond R. Kuzos died on November 20, 1994, leaving no will.

5. The legal description of the premises in question is:

The South 156 feet of the North 542 feet of the West 440 feet of the East 1490 feet of the following: The Northwest 1/4 of the Southeast 1/4 and the fractional North 1/2 of the Southwest 1/4 of Section 19, Township 35 North, Range 9 West of the 2nd Principal Meridian, in Lake County, Indiana. 11-9-122



6. To the best of affiant's knowledge there is no federal or state estate or inheritance tax liability by reason of the death of said decedent;

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? No

8. Affiant's relationship to the deceased was surviving spouse/wife.

CORINNE M. KUZOS
8151 Columbia Street
Dyer, Indiana 46311

Subscribed and sworn to before me by the affiant this 29 day of December, 1994.

Notary Public Raquel Monterrubio

My Commission Expire: 9-23-96 Resident of Lake County, IN.

This Instrument prepared by: Richard F.James, Attorney at Law
200 Monticello Drive, Dyer, IN. 46311

FILED

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ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Local No. 2974-94

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

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)
Raymond R. Kuzos	Male	5:08 A M	November 20, 1994

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)
306-34-6863	60			Dec. 18, 1933	Coal Center, Pennsylvania

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)
No	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
8151 Columbia St	Dyer	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	Corinne M. Basich	Electrician	Electrical Co

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Dyer	8151 Columbia St

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) Elementary/Secondary (0-12)	College (1-4 or 5+)
46311	☒ No ☐ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	3

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Ignatius Kuzos	Mary Burish

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
Corinne M. Kuzos	8151 Columbia St. Dyer, Indiana 46311	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 ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State	November 23, 1994 St John Cemetery	Hammond, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Edward F. Mullaney	FDO 1007176	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Edward F. Mullaney (signature)	FDO 1007176	FH83001504 Fagen-Miller Funeral Gardens Inc 1920 Hart St Dyer, Indiana 46311

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.

	Cause	Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Multiple Myeloma	3 years
DUE TO (OR AS A CONSEQUENCE OF):	Pancytopenia	8 months
DUE TO (OR AS A CONSEQUENCE OF):	Renal Failure	3 months
DUE TO (OR AS A CONSEQUENCE OF):	Cardiomyopathy	6 months

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)
No	No	

THIS CERTIFIES THAT THIS IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH FILED WITH THE LAKE COUNTY HEALTH DEPARTMENT

[signature], M.D.

LAKE COUNTY HEALTH COMMISSIONER

CERTIFIER

29a. CERTIFIER (Check only one)

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

☐ 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.

☐ 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	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	0104 1301	11/21/94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Doctor Cheryl Morgan-Ihrig 8936 Prairie Avenue Highland Indiana 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Alexander S. Williams, M.D.	November 21, 1994

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.

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RECORDER'S OFFICE SEAL