FA 14132

12/28/94 17:08 ☎219 756 3804 FIRST AM TITLE 001

HOLD FOR FIRST AMERICAN TITLE

Property Address: 9747 Redbud Road
Munster, In 46321

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

Vesna Ruiz, Affiant, states that:

95001513

1. (KRSTE) VR ~~Kreske~~ Krstevski, deceased, died on the 13th day of July, 19 90;

2. Affiant is: x the daughter of the deceased.
   ___ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ___ leaving a will which has been probated;
   ___ leaving a will which has not been probated;
   x leaving no will;

4. The deceased and Affiant acquired title along with Henry Ruiz as joint tenants with full right of survivorship to : Lot 32, Block 3, Twin Creek Subdivision to the Town of Munster, Lake County, Indiana as shown in Plat Book 49 Page 130.

Document is NOT OFFICIAL!
This Document is the property of the Lake County Recorder!
STOP

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
95 JAN -9 AM 10:10
MARSHA G. COLLINS RECORDER

5. x All expenses of the last illness and funeral of the deceased have been paid;

6. x All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. x There are no claims against the estate of the decendent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER.
JAN 9 1995
[signature] Auditor

12-29-94 — Date

[signature] — Signature of Affiant Vesna Ruiz

Vesna Ruiz — Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 29th day of December, 1994.

Printed Name of Notary

[signature] — Signature of Notary

My Commission expires: 2-5-95

My County of Residence is:

ROGER W. ZIEGELMAIER NOTARY PUBLIC COMMISSION EXP. 2-5-95 LAKE COUNTY, IN — ROGER W. ZIEGELMAIER

Prepared By: Vesna Ruiz

000366

11.00 pa

Local No. 1500-90

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Krste Krstevski
2. SEX: Male
3a. TIME OF DEATH: 06:05A M
3b. DATE OF DEATH (Month, Day, Yr): July 13, 1990
4. SOCIAL SECURITY NUMBER: 303-56-9860
5a. AGE—Last Birthday (Years): 55
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): NOV 28, 1934
7. BIRTHPLACE (City and State or Foreign Country): Bitola, Macedonia
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: [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER: [ ] Nursing Home [ ] Residence [ ] Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Methodist Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Merrillville
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Marija Zdraveski
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Steel Worker
12b. KIND OF BUSINESS/INDUSTRY: U.S. Steel
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Merrillville
13d. STREET AND NUMBER: 1355 W. 74th Place
13e. ZIP CODE: 46410
13f. INSIDE CITY LIMITS: [ ] No [X] Yes
13g. ON A FARM?: [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): Mitre Krstevic
19. MOTHER'S NAME (First, Middle, Maiden Surname): Jordanka Krstevski

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Marija Krstevski
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1355 W. 74th Place, Merrillville, Indiana 46410
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JUL 16, 1990 Calumet Park Cemetery
21c. LOCATION—City or Town, State: Merrillville, Indiana 46410
22a. EMBALMER'S NAME: Henry Blake
22b. EMBALMER'S LICENSE NO.: FDE1019406
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Robert Wiatrolik
24b. LICENSE NUMBER (of Licensee): FDE1001293
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: FH3004455 Stilinovich & Wiatrolik Funeral Home 7535 Taft Street, 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): Acute Myelogenous Leukemia — Approximate Interval Between Onset and Death: One Month

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

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 related to cause given in Part I: Cerebrovascular accident; Peripheral vascular disease

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or 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): —

CERTIFIER

29a. CERTIFIER (Check only one):
[X] 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: Barbara L Fuller, M.D.
29c. MEDICAL LICENSE NO.: 01034701
29d. DATE SIGNED (Month, Day, Year): 7/17/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. Fuller, 3229 Broadway, Gary, Indiana

HEALTH OFFICER

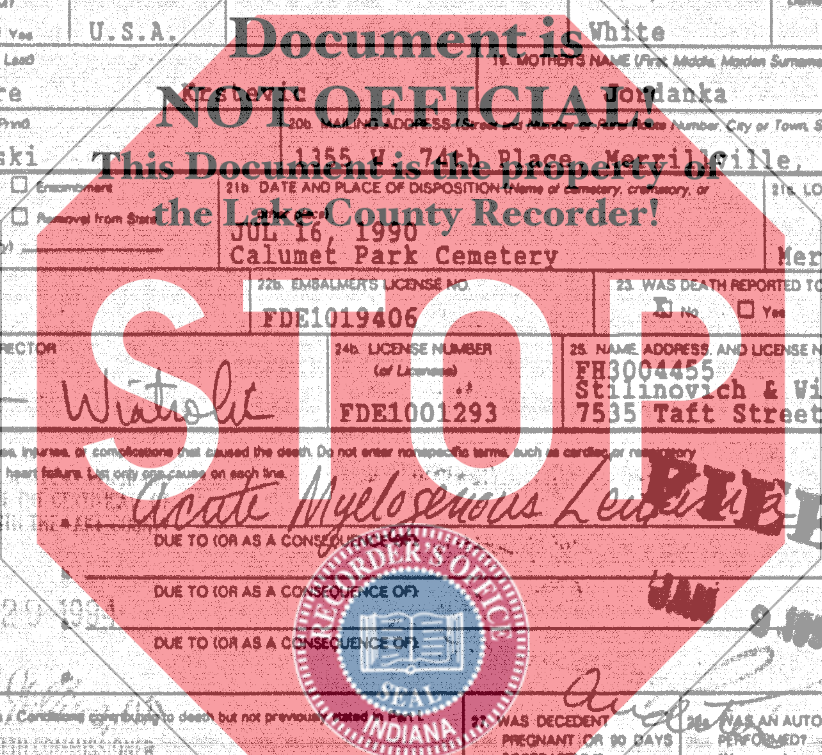
31. HEALTH OFFICER'S SIGNATURE: Paul Johnson
32. DATE FILED (Month, Day, Year): July 18, 1990

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.

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

000367



FILED JAN 9 1995
COMPLETE COPY OF THE CERTIFICATE
LAKE COUNTY HEALTH COMMISSIONER