

FA-15930

Key # 14-106-4
Unit 12

Property Address: 645 W 77th AVE
DYER, IN 46311

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

ESTATE AFFIDAVIT

Ray Grelecki, Jr., Affiant, states that:

- RAY GRELECKI, deceased, died on the 19 day of JUNE, 1985;
- Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the estate of the deceased;
- The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;
- The deceased and Affiant were married on the day of , 19 ; and were never divorced.
(This item applies only to the surviving spouse.)
- All expenses of the last illness and funeral of the deceased have been paid;
- All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;
- There are no claims against the estate of the decedent.



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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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

Date 10-23-95

Ray Grelecki, Jr.
Signature of Affiant

RAY GRELECKI, JR.
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 21th day of October, 1995.

Beth A. Kolbert
Printed Name of Notary

Beth A. Kolbert
Signature of Notary

My Commission expires: 07-11-97

My County of Residence is: Lake

Prepared By: Ray Grelecki, Jr.

Legal Description: LOT 4 IN SCHILLING'S FOURTH ADDITION TO THE TOWN OF DYER, AS SHOWN ON PLAT THEREOF, RECORDED IN PLAT BOOK 37 PAGE 78 AND MODIFIED BY CORRECTED PLAT, RECORDED IN PLAT BOOK 39 PAGE 17 AND SURVEYOR'S CERTIFICATE RECORDED NOVEMBER 14, 1968 IN MISCELLANEOUS RECORD 1020 PAGE 237 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, IN.

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1300
0303
105

HOLD FOR FIRST AMERICAN TITLE

TYPE OR PRINT
PLAINLY, WITH
UNFADING INK
THIS IS A
PERMANENT
RECORD

Return for State Office Use

- A _____
- B _____
- C _____
- D _____
- E _____
- F _____
- G _____
- H _____
- I _____
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EMBALMER'S NAME
Frank J. Kish

LICENSE No. **4539**

FUNERAL DIRECTOR'S
SIGNATURE
Frank J. Kish

FUNERAL DIRECTOR'S
LICENSE No. **2381**

FUNERAL HOME
No. **496**

Local No.

DECEASED

PARENTS


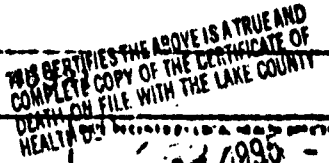
DISPOSITION

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D

CAUSE

INDIANA STATE BOARD OF HEALTH MEDICAL CERTIFICATE OF DEATH

State No.

LAST NAME KAY		FIRST NAME GRELECKI		SEX MALE	DATE OF DEATH JUNE 19, 1985
RACE White	AGE 63	UNDER 1 YEAR DATE	UNDER 5 YEAR DATE	DATE OF BIRTH Dec 7 1921	COUNTY OF BIRTH Lake
PLACE OF BIRTH Dyer		ADDRESS AND CITY AND STATE 645 West 77th Street		ZIP CODE 46311	
STATE OF BIRTH Indiana	CITIZEN OF WHAT COUNTRY U.S.A.	MARRIED AS PER MARRIAGE LICENSE MARRIED	WIFE'S NAME HELEN YAROS	MARRIAGE DATE 7 0 1 5	
SERIAL WEIGHT NUMBER 305 42 4646		USUAL OCCUPATION Self Employed		INDUSTRY OR SERVICE Service Station	
EDUCATION Ind		CITY Lake		STATE Dyer	
<p>This Document is the property of the Lake County Recorder!</p> <p style="font-size: 2em; opacity: 0.5;">RECORDED NOV 1 1995</p> <p style="font-size: 2em; opacity: 0.5;">LAKE COUNTY</p>					
FATHER'S NAME Stefan Grelecki		MOTHER'S NAME China Vnuk			
RELATIONSHIP Helen Grelecki Wife		ADDRESS 645 West 77th Street Dyer Indiana 46311			
DISPOSITION Burial		PLACE OF CREMATION Chapel Lawn		CITY Schererville, Ind.	
DATE 6/22/85		FUNERAL HOME Burns Fish Funeral Home Munster, Indiana			
DATE SIGNED June 19, 1985				TIME 8:00A.M.	
SIGNATURE <i>Dr. Fred Hartney</i>		ADDRESS 7905 Calumet Ave		CITY Munster, Indiana	
PROFESSION PHYSICIAN		<p style="text-align: center;">  </p>			
SIGNATURE <i>Paul Johnson</i>		<p style="text-align: right;">  </p>			
CAUSE MYOCARDIAL INFARCTION		<p style="text-align: right;"> OCT 23 1995 Alexander D. Gilliam, MD LAKE COUNTY HEALTH COMMISSIONER </p>			
OTHER SIGNIFICANT CONDITIONS		<p style="text-align: right;">000041</p>			

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

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2077-95

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK

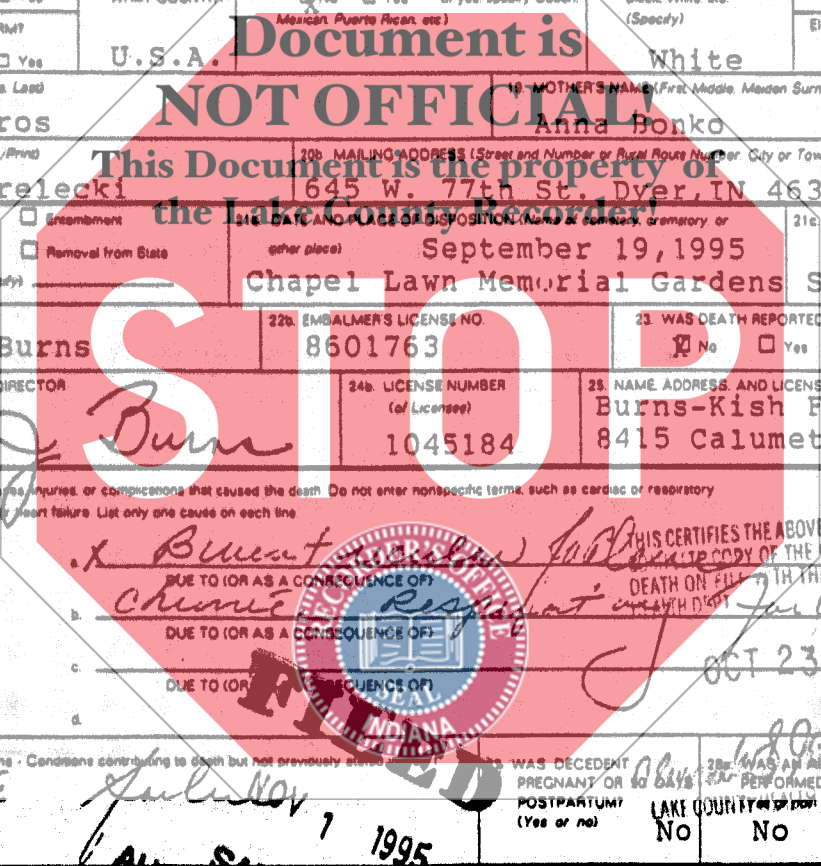
DECEDENT PARENTS INFORMATION DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Helen Grelecki		2 SEX Female	3a TIME OF DEATH 8:40P	3b DATE OF DEATH (Month, Day, Yr) September 15, 1995
4 SOCIAL SECURITY NUMBER 317-16-7120	5a AGE—Last Birthday (Years) 72	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) March 7, 1923
7 BIRTHPLACE (City and State or Foreign Country) Gary, IN	8a WAS DECEDENT A U.S. VETERAN? Wife of Vet	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N.A.	9a PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution, give street and number) St. Margaret Mercy Hospital	9c CITY, TOWN OR LOCATION OF DEATH Dyer	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Widow	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) Homemaker	12b KIND OF BUSINESS/INDUSTRY Home	
13a RESIDENCE—STATE IN	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Dyer	13d STREET AND NUMBER 645 W. 77th St.	
13e ZIP CODE 46311	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 type="checkbox"/> No <input checked="" 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) 12		18 FATHER'S NAME (First, Middle, Last) George Yaros		
19 MOTHER'S NAME (First, Middle, Maiden Surname) Anna Donko		20a INFORMANT'S NAME (Type/Print) Raymond Grelecki		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 645 W. 77th St., Dyer, IN 46311		20c Relationship Son		
21a METHOD OF DISPOSITION <input checked="" 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) September 19, 1995 Chapel Lawn Memorial Gardens Schererville, IN		21c LOCATION—City or Town, State	
22a EMBALMER'S NAME Brian T. Burns	22b EMBALMER'S LICENSE NO. 8601763	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>	24b LICENSE NUMBER (of Licensee) 1045184	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321		
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. Chronic Respiratory Failure				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) Chronic Respiratory Failure				
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last hepatic failure				
PART II: Other significant conditions—Conditions contributing to death but not previously stated hepatic failure				
27a WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) No		27b WAS AN AUTOPSY PERFORMED? No		27c WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) ----
28a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN <input type="checkbox"/> HEALTH OFFICER <input type="checkbox"/> CORONER		28b SIGNATURE AND TITLE OF CERTIFIER <i>Michael Olden</i> AUDITOR SAM ORLICH LAKE COUNTY		
28c MEDICAL LICENSE NO. X02000380		28d DATE SIGNED (Month, Day, Year) September 18, 1995		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Michael Olden, D.O. 761 45th Munster, IN 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams, MD</i>				32 DATE FILED (Month, Day, Year) Sept. 19, 1995
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
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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