



#482697

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
COUNTY OF LAKE

S. S.

On this 10-31-95 before me personally appeared Joseph Mazur

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 owner in fee simple of 1241 Kosciusko Blvd;
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Joseph Mazur and Pauline Mazur;

4. Said Pauline Mazur (fill in name of co-tenant who died)

died on 9-17-94 leaving no will; (insert 'a' or 'no'; if will left, attach a copy)

5. The legal description of the premises in question is: Lot 9, Resub. of Lots 1, 2, 3, 4, 5 and 6 in Block 5, Kosciusko Park Add. to the City of East Chicago, as shown in Plat Book 27, page 53, in Lake County, IN

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? Parties were never divorced.

(If answer is "Yes," identify the divorce proceedings:

SAM ORLICH AUDITOR LAKE COUNTY

8. Affiant's relationship to the deceased was husband

Signature: Joseph Mazur

Address: 387 Buffalo, Calumet City, IL 60409

Subscribed and sworn to before me by the affiant

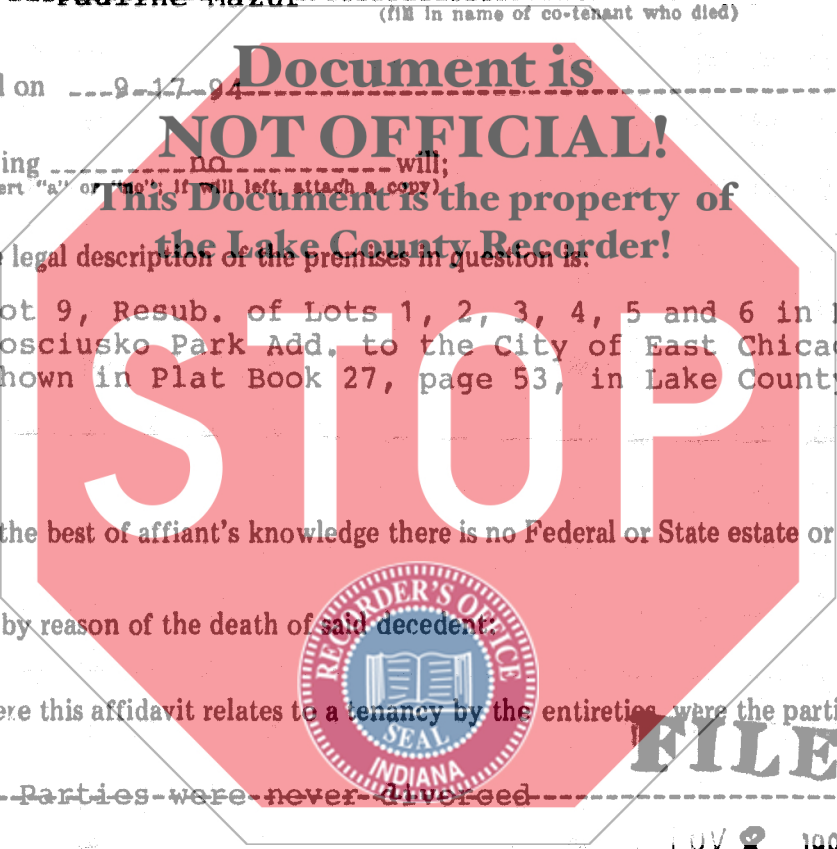
this 31st day of Oct., 1995 (insert date)

Lisa Trgovich (Signature)

Notary Public LISA TRGOVICH

My Commission Expires 9-20-99

This instrument prepared by Ray L. Szarmach 7207 Indpls. Blvd. Hammond, IN 46324



95068507

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD 95 NOV -9 AM 10:24

FILED

NOV 8 1995

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1100 at 5h

Chicago Title Insurance Company

**\*ATTENTION STATE:** Disclosure of the SS# was required to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**

Local No. **94-311**

State No. ....

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

TYPE/PRINT  
 IN  
 PERMANENT  
 BLACK INK

DECEDENT

PARENTS

INFORMANT

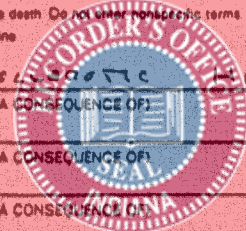
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First Middle Last) <b>Pauline A. Mazur</b>		2. SEX <b>Female</b>	3a. TIME OF DEATH <b>8:20p M</b>	3b. DATE OF DEATH (Month Day Yr) <b>September 17, 1994</b>
4. SOCIAL SECURITY NUMBER <b>311-16-2079</b>	5a. AGE—Last Birthday (Years) <b>83</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) <b>Nov. 28, 1910</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>Poland</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>-</b>	8c. PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OGA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <b>XX Residence</b>	
9a. FACILITY NAME (If not institution give street and number) <b>1211 Kosciusko Blvd.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>East Chicago</b>	9c. COUNTY OF DEATH <b>Lake</b>	
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife give maiden name) <b>Joseph Mazur</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>	12b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN OR LOCATION <b>East Chicago</b>	13d. STREET AND NUMBER <b>1211 Kosciusko Blvd.</b>	
13e. ZIP CODE <b>46312</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	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) <b>White</b>
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)   College (1-4 or 5+) <b>7</b>   <b>-</b>	18. FATHER'S NAME (First Middle Last) <b>Peter Wojcik</b>		19. MOTHER'S NAME (First Middle Maiden Surname) <b>Wojcik</b>	
20a. INFORMANT'S NAME (Type, Print) <b>Joseph Mazur</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1211 Kosciusko, E.Chgo, IND 46312</b>	20c. Relationship <b>Husband</b>	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>September 20, 1994 Holy Cross Cemetery</b>		21c. LOCATION—City or Town, State <b>Calumet City, Illinois</b>
22a. EMBALMER'S NAME <b>James H. Fife</b>	22b. EMBALMER'S LICENSE NO. <b>FD01010795</b>	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John P. Fife</i>	24b. LICENSE NUMBER (of Licensee) <b>FD01020366</b>	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>FIFE FUNERAL HOME - FH83001512 4201 Indpls. Blvd., E.Chgo, IND</b>		
26. PART I: Enter the disease, injuries, or complications that caused the death. Do not enter non-specific 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. <b>ATHEROSCLEROTIC HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____ Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.				Approximate Interval Between Onset and Death <b>16</b>
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>DIABETES</b>		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>	28. AUTOPSY PERFORMED? (Yes or no) <b>No</b>	29. AVALANCHE FINDINGS AVAILABLE TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>-</b>
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>[Signature]</i>		29c. MEDICAL LICENSE NO. <b>01025435</b>	29d. DATE SIGNED (Month Day, Year) <b>Sept. 19, 1994</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Timothy W. Raykovich, M.D. - 6924 Indianapolis Blvd., Hammond, Indiana</b>				
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month Day, Year) <b>9-23-94</b>	
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.		



**FILED**

**NOV 8 1995**

**SAM ORLICH AUDITOR LAKE COUNTY**

**000501**

Chicago Title Insurance Company