

*Proper Bal*

# TICOR TITLE INSURANCE

## AFFIDAVIT

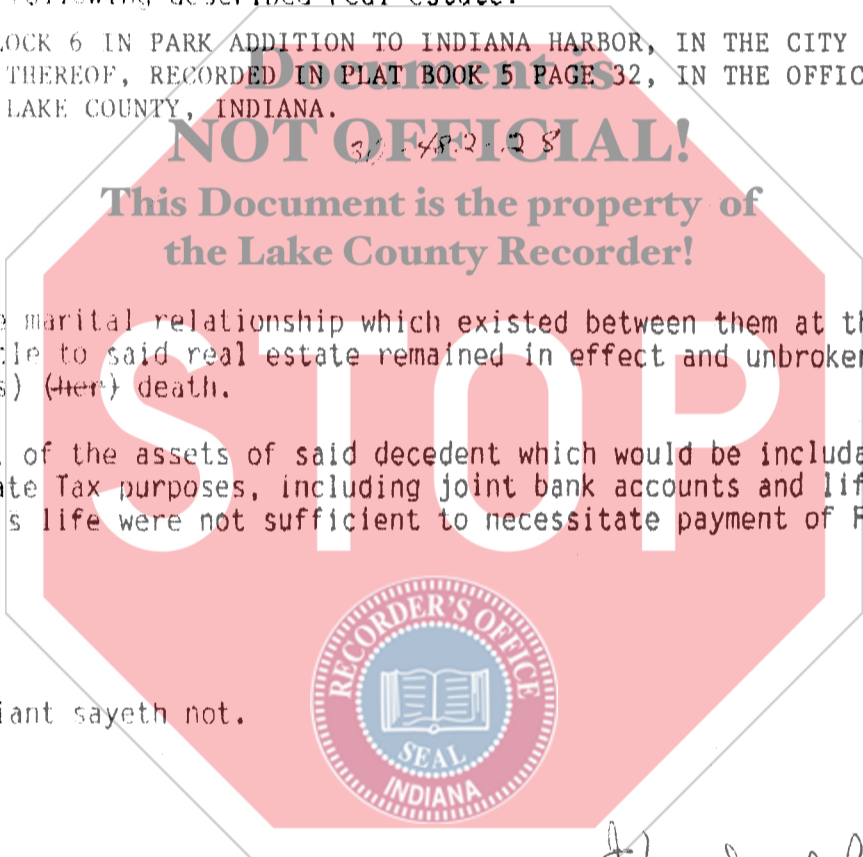
STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

ELIZABETH BALON, being first duly sworn upon oath, deposes and says:

1. That LEONARD E. BALON died on JUNE 16, 1994 at 9:40pm AT VENCOR HOSPITAL LA GRANGE

2. That LEONARD E. BALON and ELIZABETH BALON were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

LOT 28 IN BLOCK 6 IN PARK ADDITION TO INDIANA HARBOR, IN THE CITY OF EAST CHICAGO AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 5 PAGE 32, 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 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.

*Elizabeth Balon*  
Elizabeth Balon

Subscribed and sworn to before me, a Notary Public, this 9TH day of APRIL, 19 96.

**FILED**

APR 16 1996

**SAM ORLICH**  
**AUDITOR LAKE CCUNTY**

*Yvonne M. Perez*  
YVONNE M. PEREZ Notary Public

My Commission expires:

APRIL 19, 1999

County of Residence:

LAKE

This Instrument prepared by YVONNE M. PEREZ

96024629

STATE OF INDIANA  
LAKE COUNTY  
FILED  
RECORDER  
96 APR 17 AM 9:57

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TICOR TITLE INSURANCE

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to  
see

# LaGRANGE COUNTY CERTIFICATE OF DEATH

*Respectful*

200470

THIS IS AN OFFICIAL COPY OF THE RECORD OF DEATH ON FILE AT THE LaGRANGE COUNTY HEALTH DEPARTMENT:

1 DECEASED—NAME (First Middle Last) <b>Leonard E. Balon</b>				2. SEX <b>Male</b>		3a. TIME OF DEATH <b>9:40P M</b>		3b. DATE OF DEATH (Month Day Yr) <b>June 16 1994</b>	
4. SOCIAL SECURITY NUMBER <b>314-26-8962</b>		5a. AGE—Last Birthday (Year) <b>63</b>		5b. UNDER 1 YEAR Months: Days:		5c. UNDER 1 DAY Hours: Minutes:		6. DATE OF BIRTH (Mo. Day, Yr) <b>July 19, 1930</b>	
6a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>		6b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1952</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>East Chicago, IN</b>		8. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Present <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a. FACILITY NAME (If not institution, give street and number) <b>Vencor Hospital LaGrange</b>				9b. CITY, TOWN, OR LOCATION OF DEATH <b>LaGrange</b>		9c. COUNTY OF DEATH <b>LaGrange</b>			
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>Elizabeth Sandor</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Store Room Manager</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Municipal-City Go</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>4112 Fir St.</b>		17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)	
13e. ZIP CODE <b>46312</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEY OF WHAT COUNTRY? <b>USA</b>		15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>	
18. FATHER'S NAME (First Middle Last) <b>Anton Balon</b>				19. MOTHER'S NAME (First Middle, Maiden Surname) <b>Helen Szafranec</b>				20c. Relationship <b>Wife</b>	
20a. INFORMANT'S NAME (Type/Print) <b>Elizabeth Balon</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4112 Fir St., East Chicago, IN 46312</b>				20c. Relationship <b>Wife</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Entombment <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) <b>June 19, 1994 Central Michigan Crematory</b>		21c. LOCATION—City or Town, State <b>Battle Creek, MI</b>		22. EMBALMER'S NAME <b>No Embalming</b>			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Jon R. Thornton</i>		24b. LICENSE NUMBER (of Licensee) <b>N/A</b>		24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Frurip-May F.H. FH 83003988 309 W. Mich., LaGrange, IN 46761</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
25. 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) a. <b>Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>Atherosclerotic heart disease</b> DUE TO (OR AS A CONSEQUENCE OF) c. <b>COPD</b> DUE TO (OR AS A CONSEQUENCE OF) Approximate Interval Between Onset and Death <b>12M</b>									
PART II: Other significant conditions. Conditions contributing to death but not previously stated in Part I. <b>Diabetes</b>									
26a. 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.		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>No</b>		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>No</b>		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Reed Taylor</i>						29c. MEDICAL LICENSE NO. <b>01019129</b>		29d. DATE SIGNED (Month Day Year) <b>June 17, 1994</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28b) (Type/Print) <b>M. Reed Taylor, M.D., 0080 - 600 N. Howe, IN 46746</b>									
31. HEALTH OFFICER'S SIGNATURE <i>Anthony Taylor</i>									
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) <b>6-17-94</b>		34b. TIME OF INJURY		34c. INJURY AT WORK? (Yes or no)		34d. DESCRIBE HOW INJURY OCCURRED	
34a. PLACE OF INJURY. At home, farm, street, factory, office, building, etc. (Specify)				34e. 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.							

LOCAL HEALTH OFFICER

NOT OFFICIAL  
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