

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

FILED

96 APR 18 AM 9:12 APR 15 1996

MARGARETTE CLEVELAND
RECORDER

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA,
COUNTY OF LAKE

96025128

) SS:
)

SURVIVORSHIP AFFIDAVIT

Comes now EMERY FAZEKAS, affiant herein, and being duly sworn upon oath, deposes and says as follows:

1. That affiant resides at 2828 Cleveland, Hammond, Indiana.

Legally described as follows:
Lot 16, Block 6, Turner-Meyn Park,
Key No. 36-253-~~17~~16

2. That affiant is the owner of the above-described premises which were formerly owned by affiant and Helen Fazekas, deceased, as tenants by the entireties.

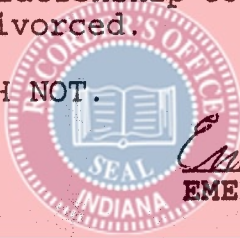
3. That said decedent died on January 6, 1996, leaving no will.

4. That the total value of the taxable estate of said decedent, including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, does not exceed the sum of \$1,000.00.

5. That to the best affiant's knowledge there is no estate or inheritance tax liability by reason of the death of said decedent.

6. That affiant's relationship to the deceased was spouse and that parties were never divorced.

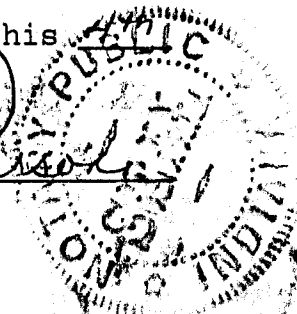
FURTHER AFFIANT SAITH NOT.



Emery Fazekas
EMERY FAZEKAS

Subscribed and sworn to before me a Notary Public this ~~March~~ April, 1996.

Lorraine [Signature]
NOTARY PUBLIC



MY COMMISSION EXPIRES: FEBRUARY 1, 2000

This instrument prepared by Carmen A. Fernandez, Member, Indiana Bar, #6814-45, 7207 Indianapolis Blvd., Hammond, IN 46324
219-845-9540

1100
va
#2442

000799

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

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 0063-96

CERTIFICATE OF DEATH

State No.

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) Helen B. Fazekas				2. SEX Female		3a. TIME OF DEATH 7:00 P M		3b. DATE OF DEATH (Month, Day, Yr) January 6, 1996	
4. SOCIAL SECURITY NUMBER 304-64-9999		5a. AGE—Last Birthday (Years) 82		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) Sept. 22, 1913	
7. BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana		8a. WAS DECEDENT A U.S. VETERAN? No							
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <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							
9a. FACILITY NAME (If not institution, give street and number) The Community Hospital				9b. CITY, TOWN, OR LOCATION OF DEATH Munster			9c. COUNTY OF DEATH Lake		
10. MARITAL STATUS Married		11. SURVIVING SPOUSE (If wife, give maiden name) Emery Fazekas		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 Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Hammond			13d. STREET AND NUMBER 2828 Cleveland Street		
13e. ZIP CODE 46323		13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input 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) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+)				18. FATHER'S NAME (First, Middle, Last) Thomas Pucalik					
19. MOTHER'S NAME (First, Middle, Maiden Surname) Berniece Racik						20a. INFORMANT'S NAME (Type/Print) Mr. Emery Fazekas			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2828 Cleveland St., Hammond, IN 46323				20c. Relationship Husband					
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) January 9, 1996 Ridgelawn/Mt. Mercy Cemetery Gary, Indiana			21c. LOCATION—City or Town, State			
22a. EMBALMER'S NAME George J. Johnson			22b. EMBALMER'S LICENSE NO. 0890006			23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Schauer, Jr.</i>			24b. LICENSE NUMBER (of Licensee) 1006049		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME VIRGIL HUBER Funeral Home-3002869 7051 Kennedy, Hammond, IN 46323				
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. Coronary Artery Disease IMMEDIATE CAUSE (Final disease or condition resulting in death) FILED DUE TO (OR AS A CONSEQUENCE OF) CONDITIONS, if any, which give rise to the immediate cause, stating the underlying cause last APR 15 1996									
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. SAM ORLICH AUDITOR LAKE COUNTY									
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No			28a. WAS AN AMNIOTIC FLUID MASS PERFORMED? (Yes or no) No			28b. WERE ANY FINDINGS COMPLETED PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/a			
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. 01031764		29d. DATE SIGNED (Month, Day, Year) January 10, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Prakash Makam, M.D., 9122 Columbia Ave., Munster, Indiana 46321									
31. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams, M.D.</i>							32. DATE FILED (Month, Day, Year) January 10, 1996		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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	
34a. 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. 00495					

DECEDENT

PARENTS

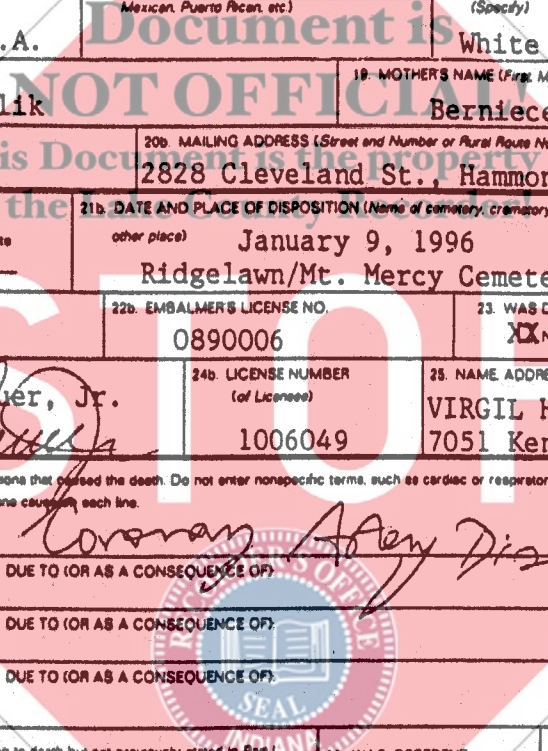
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



THIS CERTIFIES THE ABOVE IS A COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT

JAN 11 1996