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TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

BILL KOLLINTZAS
~~XXXXXXXXXXXXXXXXXXXX~~

_____, being first duly sworn upon oath, deposes and says:

1. That **PETER KOLLINTZAS** died on JANUARY 24, 1996 at EAST CHICAGO, IN

2. That **PETER KOLLINTZAS** and **MARIGO KOLLINTZAS** were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 8, except the South 1 foot thereof, in Block 20 in 2nd Addition to Indiana Harbor in the City of East Chicago, as per plat thereof, recorded in Plat Book 5 page 18, in the Office of the Recorder of Lake County, Indiana.

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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 funeral expenses in connection with the death of said decedent have been paid in full.

5. 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.

FILED



OCT 3 1996

Bill Kollintzas
BILL ~~MARIGO~~ KOLLINTZAS

Subscribed and sworn to before me, a Notary Public, this 30th day of SEPTEMBER, 1996

Gloria Miller
GLORIA MILLER Notary Public

My Commission expires:
10-24-2000

County of Residence:
LAKE

BILL
~~MARIGO~~ KOLLINTZAS

This Instrument prepared by _____



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96 OCT -4 AM 9:57

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

* ATTENTION ESTATE: The Social Security Act is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

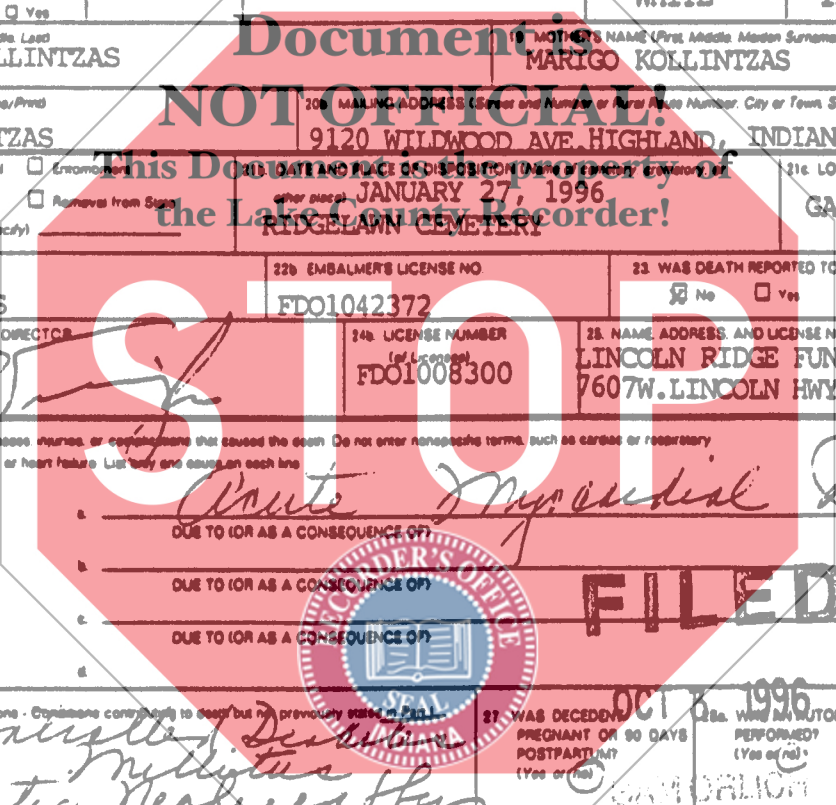
State No.

Local No. 96-30

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First Middle Last) PETER A. KOLLINTZAS		2. SEX MALE	3a. TIME OF DEATH 7:22P	3b. DATE OF DEATH (Month Day Year) JANUARY 24, 1996
4. SOCIAL SECURITY NUMBER 307-40-7383	5a. AGE—Last Birthday (Years) 83	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Month Day Year) AUGUST 1, 1912
7. BIRTHPLACE (City and State or Foreign Country) GREECE	8a. WAS DECEDENT A U.S. VETERAN? NO			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE		8c. PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <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) ST. CATHERINE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH EAST CHICAGO	9c. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) MARRIED	11. SURVIVING SPOUSE (If wife, give maiden name) MARIGO DRAKOPOULS	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) COOK	12b. KIND OF BUSINESS/INDUSTRY RESTURANT INDUSTRY	
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN OR LOCATION EAST CHICAGO	13d. STREET AND NUMBER 3815 PARRISH AVE.	
13e. ZIP CODE 46312	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 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 any highest grade completed) Elementary/Secondary (0-12) 12		18. FATHER'S NAME (First Middle Last) ANTHONY KOLLINTZAS		
19. MOTHER'S NAME (First Middle Maiden Surname) MARIGO KOLLINTZAS		20a. INFORMANT'S NAME (Type/Print) TONY KOLLINTZAS		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9120 WILDWOOD AVE. HIGHLAND, INDIANA		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 (Date, City or Town, State, Zip Code) JANUARY 27, 1996 RIDGELAWN CEMETERY		21c. LOCATION—City or Town, State GARY, INDIANA
22a. EMBALMER'S NAME CHARLES WELLS		22b. EMBALMER'S LICENSE NO. FDO1042372	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of License) FDO1008300	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607W. LINCOLN HWY. CROWN POINT, IND. 46307	
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. Acute Myocardial Infarction		26. PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I. Uncontrolled Diabetes Mellitus Diabetic Nephropathy		
27. IMMEDIATE CAUSE (Final disease or condition resulting in death) Acute Myocardial Infarction		28. DUE TO IOR AS A CONSEQUENCE OF		
29. CONDITIONS, if any, which gave rise to the immediate cause causing the underlying cause last		30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		
31. 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.		32a. MEDICAL LICENSE NO. 01027460		32b. DATE SIGNED (Month, Day, Year) JAN. 29, 1996
33. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/print) 720 W. Chicago Ave. East Chicago, In. 46312		
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) 1-29-96		
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. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED		
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.		34i. DATE FILED (Month, Day, Year)		



FILED

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