CTC 12959

COMMUNITY TITLE COMPANY
— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

96083005

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

VERA WOLUCKA, being first duly sworn upon oath, deposes and says:

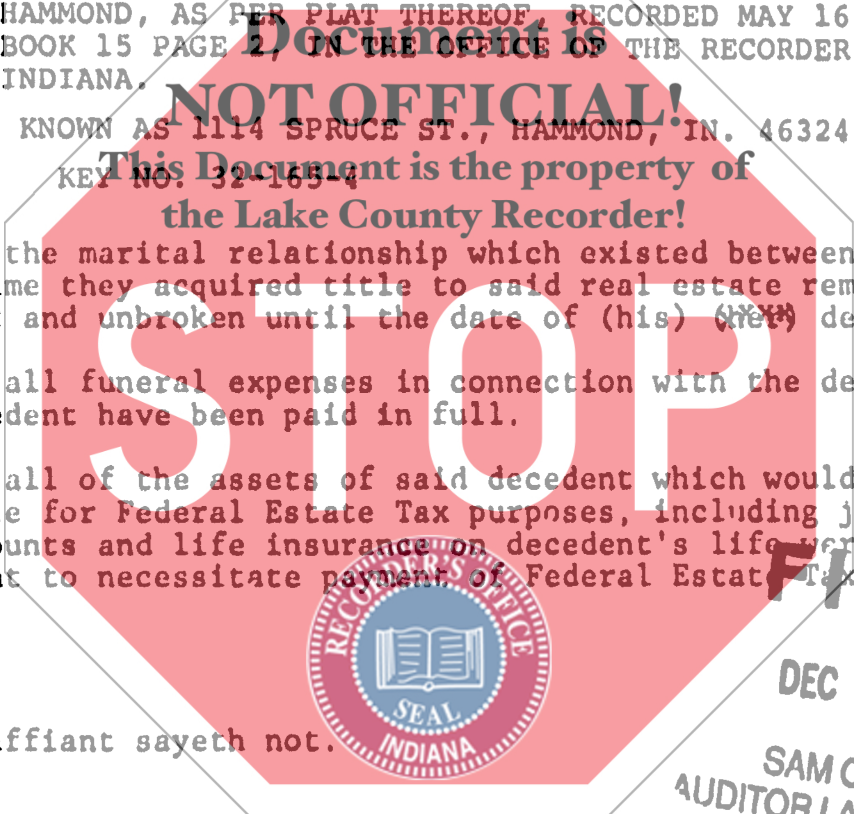
1. That Affiant's spouse, JOSEPH WOLUCKA died (without leaving a will) XXXXXXXXXXXXXXXXX on September 8, 1994 at Community Hospital, Munster, Indiana

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

THE WEST 1/2 OF LOT 5 IN BLOCK 4 IN COLUMBIA GARDENS, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED MAY 16, 1921 IN PLAT BOOK 15 PAGE 2, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 1114 SPRUCE ST., HAMMOND, IN. 46324

UNIT 26 KEY NO. 32-165-4



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
96 DEC 16 AM 10:43
RECORDER

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) (XXX) 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.

FILED
DEC 16 1996
SAM ORLICH
AUDITOR LAKE COUNTY

Further affiant sayeth not.

Vera Wolucka
VERA WOLUCKA

Subscribed and sworn to before me, a Notary Public, this 6th day of December, 1996.

[signature]
Notary Public

My Commission expires:

____

County of Residence:

____

Daniel W. Slusser
Notary Public, State of Indiana
Lake County
My Commission Exp. 08/03/2000

This Instrument prepared by RICHARD PARKS, ATTORNEY AT LAW

003995

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 2165-94 State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): JOSEPH WOLUCKA
2. SEX: Male
3a. TIME OF DEATH: 11:45 AM
3b. DATE OF DEATH (Month Day Yr): September 8, 1994
4. SOCIAL SECURITY NUMBER: 310-01-1023
5a. AGE—Last Birthday (Years): 81
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Month Day Yr): November 8, 1912
7. BIRTHPLACE (City and State or Foreign Country): Hammond, Indiana
8a. WAS DECEDENT A U.S. VETERAN?: no
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: --
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Community Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Munster
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Vera Jewell
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Grinder
12b. KIND OF BUSINESS/INDUSTRY: Foundry
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 1114 Spruce St.
13e. ZIP CODE: 46324
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): John Wolucka
19. MOTHER'S NAME (First Middle Maiden Surname): Anastasia Serbin

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Vera Wolucka
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1114 Spruce St., Hammond, Indiana 46324
20c. Relationship: Wife

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 12, 1994 Elmwood Cemetery
21c. LOCATION—City or Town, State: Hammond, Indiana
22a. EMBALMER'S NAME: Dean G. Wagner
22b. EMBALMER'S LICENSE NO.: # 8800057
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]
24b. LICENSE NUMBER (of Licensee): FD# 1007231
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH# 83002893, 7109 Calumet Ave., Hammond, Ind. 46324

CAUSE OF DEATH

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Hepatic Encephalopathy and Hem[illegible]

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

DUE TO (OR AS A CONSEQUENCE OF): b. Sinto hypertension

DUE TO (OR AS A CONSEQUENCE OF): c. Cirrhosis of the Liver

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I: Esophageal Varices; Ascites

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): no
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): no
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): --

CERTIFIER

29a. CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) as stated.
☐ 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.
☐ 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: [signature]
29c. MEDICAL LICENSE NO.: 0108325
29d. DATE SIGNED (Month Day Year): September 9, 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Carlos Serna M.D., 2342 Ridge Road, Highland, Indiana 463232

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams, M.D.
32. DATE FILED (Month Day Year): September 12, 19

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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.

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

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