207656-GARCIA

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TICOR TITLE INSURANCE

V

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

CARRIE KUCKEN, being first duly sworn upon oath, deposes and says:

1. That EDWARD KUCKEN died on APRIL 15, 19 96 at LAKE COUNTY, IN.

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

LOT 41 IN BLOCK 2 IN THE RESUBDIVISION OF PART OF THE WEST 1317.5 FEET OF THE NORTHEAST 1/4 OF SECTION 29, TOWNSHIP 37 NORTH, RANGE 9 WEST OF THE 2ND PRINCIPAL MERIDIAN, IN THE CITY OF EAST CHICAGO, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 5 PAGE 2, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

30-14-35

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.

Carrie Kucken
CARRIE KUCKEN

Subscribed and sworn to before me, a Notary Public, this 27TH day of MARCH, 19 97.

Notary Public

County of Residence - Lake

My Commission expires:

THOMAS G. SCHILLER NOTARY PUBLIC LAKE COUNTY, INDIANA Exp. 6/7/00

County of Residence:

This Instrument prepared by Carrie Kucken

TICOR TITLE INSURANCE
HO Crown Point, Indiana

CCC012

* ATTENTION ESTATE: The Social Security # 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

Local No. 0772-96 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)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Edward W. Kucken	Male	5:47a M	April 15, 1996

4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
312-10-9937	83			July 24,1912	East Chicago, Indiana

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
No	-	HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER XX Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution give street and number)	9c CITY TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
Dyer Nursing Center	Dyer	Lake

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
Married	Carrie L. Rogowski	Chemical Operator	Union Carbide Corp.

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	East Chicago	4111 Olcott Avenue

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF WHAT COUNTRY?	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban Mexican Puerto Rican etc)	16 RACE—American Indian Black White etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46312	☐ No XX Yes	XX No	U.S.A.	☐ No ☐ Yes	White	8	-

PARENTS

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Robert Kucken	Emily Kasprzyk

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
Carrie L. Kucken	4111 Olcott Ave., East Chicago, IND 46312	Wife

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	April 18, 1996 Holy Cross Cemetery	Calumet City, Illinois

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
James H. Fife	FD01010795	XX No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John B. Fife	FD01020366	FIFE FUNERAL HOME - FH83001512 4201 Indpls.Blvd., E.Chgo, IND

I CERTIFIED THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE IN THIS OFFICE

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 Link only one cause on each line

		Approximate Interval Between Onset and Death
a. IMMEDIATE CAUSE (Final disease or condition resulting in death)	✓ Cardiopulmonary Arrest	
b. DUE TO (OR AS A CONSEQUENCE OF)	Bladder Tumor	
c. DUE TO (OR AS A CONSEQUENCE OF)		
d. DUE TO (OR AS A CONSEQUENCE OF)		

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

Alexander D. Williams, M.D.
LAKE COUNTY HEALTH COMMISSIONER

APR 16 1996

FILED
APR 01 1997
SAM ORLICH
AUDITOR LAKE COUNTY

PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I

Renal failure
Non-insulin dependent diabetes mellitus

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

CERTIFIER

29a CERTIFIER (Check only one)

XX 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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month Day Year)
✓ J. Paik, M.D.	✓ 30770	April 15, 1996

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

Jay Paik, M.D. - 200 Monticello Drive, Dyer, Indiana 46311

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Alexander D. Williams, M.D.	April 16, 1996

33 MANNER OF DEATH	34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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)
	000013

34g DATE PRONOUNCED DEAD (Month Day Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc