

2



TICOR TITLE INSURANCE

807947 Ticor-Hbart

97019695

AFFIDAVIT

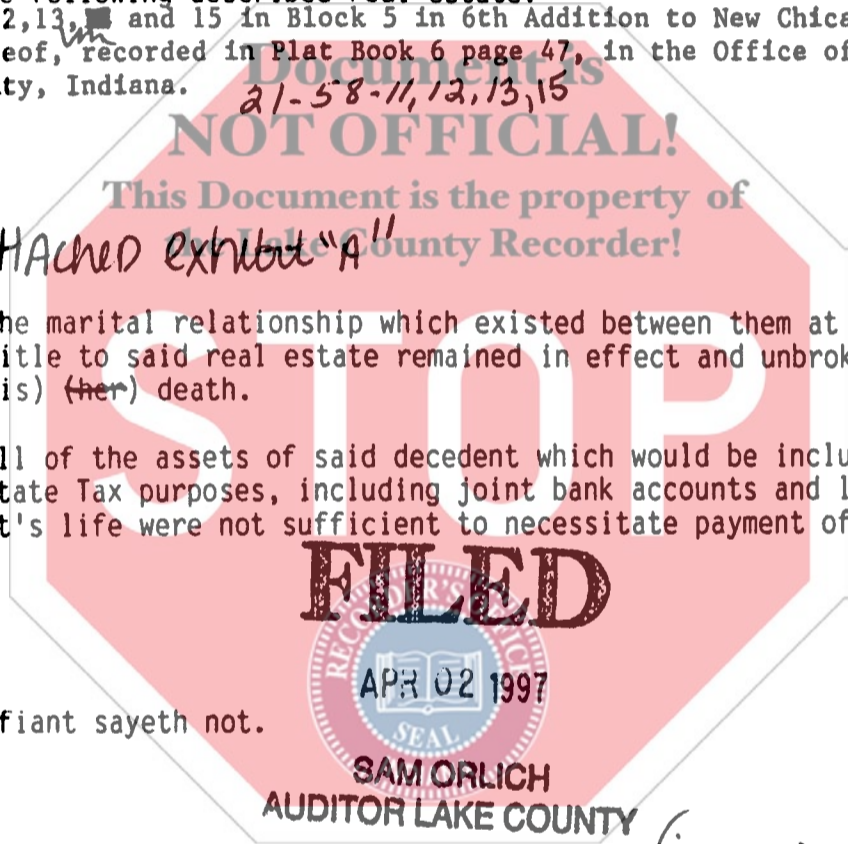
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Virgie Minarich, being first duly
sworn upon oath, deposes and says:

1. That Michael Minarich died on
June 9, 1993 at 3:00pm

2. That Michael Minarich and Virgie Minarich
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate:
Lots 11,12,13, and 15 in Block 5 in 6th Addition to New Chicago, as per
plat thereof, recorded in Plat Book 6 page 47, in the Office of the Recorder of
Lake County, Indiana. 21-58-11,12,13,15

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
97 APR -3 AM 10:11
MORRIS W. CARTER
RECORDER



see ATTACHED exhibit "A"

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.

Virgie Minarich

Subscribed and sworn to before me, a Notary Public, this 28th day of
March, 1997

Jacalyn L. Smith
Notary Public

Jacalyn L. Smith

My Commission expires:

12/08/99

County of Residence:
Lake

000084

This Instrument prepared by Virgie Minarich

11:00
DJ T1

on Recording
Mail to: Virgie Minarich
115 Madison
INDIANA 46312

EXHIBIT "A"

8 Key
2 Vet
10 Total

ical No. ... CERTIFICATE OF DEATH State No. ...

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3 TICOR 207947 HOBART

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) MICHAEL P. MINARICH		2 SEX Male	3a TIME OF DEATH 3:00P M	3b DATE OF DEATH (Month Day Yr) June 9, 1993
4 SOCIAL SECURITY NUMBER 316-09-0018	5a AGE—Last Birthday (Years) 80	5b UNDER 1 YEAR Month Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) JUL 8, 1912
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one. See instructions) <input type="checkbox"/> Hospital <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence		

DECEDENT

9b FACILITY NAME (If not institution give street and number) 115 MADISON STREET		9c CITY TOWN OR LOCATION OF DEATH HOBART	9d COUNTY OF DEATH LAKE
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) VIRGIE CRAWFORD	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use "retired") STRAIGHTENER	12b KIND OF BUSINESS/INDUSTRY U.S. STEEL

PARENTS

13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION HOBART	13d STREET AND NUMBER 115 MADISON STREET
13e ZIP CODE 46342	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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) 8 College (13 or 6+)		

INFORMANT

18 FATHER'S NAME (First Middle Last) MICHAEL MINARICH	19 MOTHER'S NAME (First Middle Maiden Surname) JULIA RAGVEY	
20a INFORMANT'S NAME (Type/Print) VIRGIE MINARICH	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 MADISON ST, HOBART, INDIANA 46342	20c Relationship Wife

IDENTIFICATION
COMPLETE COPY OF THE DEATH ON FILE WITH THE HEALTH DEPT

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) JUN 12, 1993 EVERGREEN MEMORIAL PARK	21c LOCATION—City or Town, State HOBART, INDIANA
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IDENTIFICATION

22a EMBALMER'S NAME (Type/Print) JAMES J. KRAUSE	22b EMBALMER'S LICENSE NO. FDO1006463	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a LICENSE NUMBER (of Licensee) FDO1006463	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 REES FUNERAL HOMES INC. 600 W. RIDGE RD, HOBART, TN 46342	

AUS EAT
LAKE COUNTY

26 PART I Enter the disease, 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
Conditions if any which give rise to the immediate cause

a **Vascular collapse**

b **Due to arteriosclerotic heart and vascular disease**

c

Approximate Interval Between Onset and Death
Unknown

STATE DEPARTMENT OF HEALTH
LAKE COUNTY
FILED FOR RECORD
MAY 18 1993

CERTIFIER

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

27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)
N/A

28a WAS AN AUTOPSY PERFORMED? (Yes or no)
No

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No

HEALTH OFFICER

29a CERTIFIER (Check only one)
 CERTIFYING PHYSICIAN To my personal knowledge, death occurred at the time, date and place and due to the cause(s) as stated
 HEALTH OFFICER To the best of my knowledge and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) as stated

Chief Deputy CORONER
Deborah Huseman

29b SIGNATURE AND TITLE OF CERTIFIER
Deborah Huseman

29c MEDICAL LICENSE NO.
N/A

29d DATE SIGNED (Month Day Year)
June 14, 1993

CRONER
SE ONLY

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print)
Deborah Huseman, Chief Deputy Coroner, 2293 North Main Street, Crown Point, Indiana 46307

31 HEALTH OFFICER'S SIGNATURE
Deborah Huseman, MD

32 DATE FILED (Month Day Year)
June 14, 1993

33 MANNER OF DEATH <input checked="" 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 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)
June 9, 1993

34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc
NO