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MORRIS W. CARTER
RECORDER

STATE OF INDIANA)
COUNTY OF LAKE) SS:

SURVIVORSHIP AFFIDAVIT

COMES NOW MARIE S. MARTIN, and first being duly sworn upon oath says as follows:

- (1.) That I am the surviving widow of NOVO MARTIN, deceased, and I have personal knowledge of the facts set forth in this affidavit.
- (2.) That NOVO MARTIN died on August 19, 1996, a resident of Lake County, Indiana, and a true and correct copy of his Certificate of Death is attached as Exhibit "A", and no estate proceedings have been filed or are contemplated in connection with his death.
- (3.) That NOVO MARTIN and I were lawfully married on April 19, 1944, and remained continuously married until his death.
- (4.) That at the time of his death NOVO MARTIN and I, as husband and wife, owned the following-described real estate in Lake County, Indiana:
All of Lot 31, Block 2, L.B. Snowden's Oak Grove Addition to the City of Gary as per plat thereof recorded in Plat Book 20, page 10, in the Office of the Recorder of Lake County, Indiana, and commonly referred to as 4601 Lincoln Street, Gary, Indiana.
- (5.) That NOVO MARTIN'S estate was not subject to Federal Estate Tax.
- (6.) That affiant further sayeth naught.

Marie S. Martin
Marie S. Martin

BEFORE ME, a Notary Public in and for said County and State, personally appeared MARIE S. MARTIN, who acknowledged her execution of the foregoing as a free act and deed.

IN WITNESS WHEREOF I have hereunto set my hand and seal this 9TH day of March, 1997.

My Commission Expires:
June 22, 1997

James T. Walker
James T. Walker, Notary Public
Resident of Lake County

Prepared by: James T. Walker, Attorney at Law, 99 East 86th Avenue, Suite E, Merrillville, Indiana 46410
Return to: James T. Walker, Attorney at Law, 99 East 86th Avenue, Suite E, Merrillville, Indiana 46410

FILED

APR 15 1997

SAM ORLICH
AUDITOR LAKE COUNTY

000528

James T Walker
Professional Corporation
99 East 86th

1100
SM

CLCKH 6353

ATTENTION ESTAYE: 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.

10 CC's
INDIANA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

State No.

Local No. 2641 A6

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

41176
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS
INFORMANT

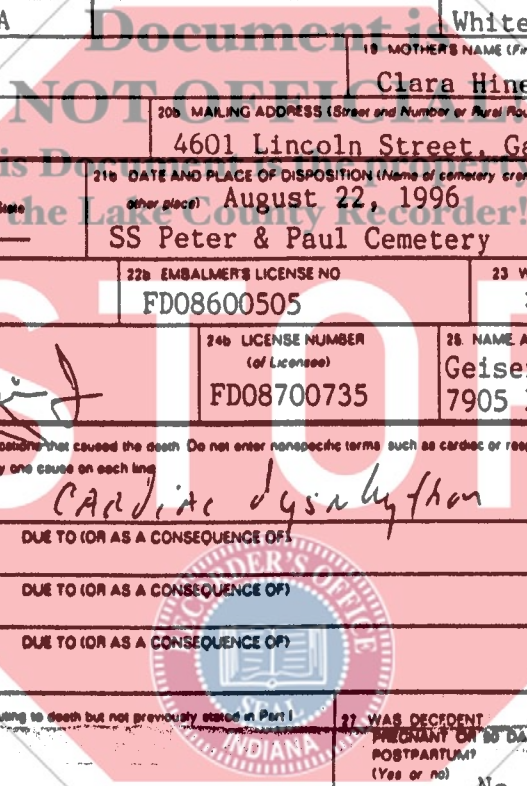
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

| | | | | |
|---|--|--|--|--|
| 1 DECEASED—NAME (First Middle Last) Novo J Martin | | 2 SEX Male | 3a TIME OF DEATH 6:26 A | 3b DATE OF DEATH (Month Day Year) August 19, 1996 |
| 4 SOCIAL SECURITY NUMBER 309-14-5123 | 5a AGE—Last Birthday (Year) 76 | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Month Day Year) April 11, 1920 |
| 7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana | 8a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence | | | |
| 9a WAS DECEDENT A U.S. VETERAN? Yes | 9b YEAR LAST SERVED IN U.S. ARMED FORCES? 1945 | 9c FACILITY NAME (If not institution, give street and number) St. Mary Medical Center | | |
| 9d CITY, TOWN OR LOCATION OF DEATH Hobart | | 9e COUNTY OF DEATH Lake | | |
| 10 MARITAL STATUS (Specify) Married | 11 SURVIVING SPOUSE (If wife, give maiden name) Marie Fleck | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Assistant Chief | | 12b KIND OF BUSINESS/INDUSTRY Gary Fire Department |
| 13a RESIDENCE—STATE Indiana | 13b COUNTY Lake | 13c CITY, TOWN OR LOCATION Gary | | 13d STREET AND NUMBER 4601 Lincoln Street |
| 14 ZIP CODE 46408 | 15 INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes 15a ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | 16 CITIZEN OF WHAT COUNTRY? USA | 17 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 18 RACE—American Indian, Black, White, etc. (Specify) White |
| 19 FATHER'S NAME (First Middle Last) Widin Maryonovich | | 20 MOTHER'S NAME (First Middle Maiden Surname) Clara Hiney | | |
| 21a INFORMANT'S NAME (Type/Print) Marie Martin | | 21b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 Lincoln Street, Gary, Indiana 46408 | | 21c Relationship Wife |
| 22a 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) | | 22b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 22, 1996 SS Peter & Paul Cemetery | | 22c LOCATION—City or Town, State Merrillville, Indiana |
| 23a EMBALMER'S NAME Alexis Thanos | | 23b EMBALMER'S LICENSE NO. FD08600505 | | 23c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert A. Craig</i> | | 24b LICENSE NUMBER (of Licensee) FD08700735 | | 24c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. FH83007762 7905 Broadway Merrillville, IN 46410 |
| 25 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. <i>Cardiac dysrhythmia</i> | | | | |
| 25 PART II This certificate above is a true and complete copy of the certificate of death on file with the Lake County Health Dept. Consider if any, which give rise to the immediate cause using the following cause list: <i>AUG 23 1996</i> | | | | |
| 26 PART III Other conditions contributing to death but not previously stated in Part I <i>Alexis Thanos, M.D. LAKE COUNTY HEALTH COMMISSIONER</i> | | 27 WAS DECEDENT PREGNANT OR 30 DAYS POSTPARTUM? (Yes or no) No | 28 WAS AN AUTOPSY PERFORMED? (Yes or no) No | 29 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No |
| 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>M. H. Gasparis</i> | | 29c MEDICAL LICENSE NO. 362092827 | 29d DATE SIGNED (Month Day Year) 8/22/96 | |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 25) (Type/Print) Dr. Milton Gasparis 1400 S. Lake Park Ave., Suite 301, Hobart, Indiana 46342 | | | | |
| 31 HEALTH OFFICER'S SIGNATURE <i>Alexis Thanos, M.D.</i> | | | | 32 DATE FILED (Month Day Year) August 23, 1996 |
| 33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> 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) 000823 | | 34g DATE PRONOUNCED DEAD (Month Day Year) | | |
| 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. | | | | |



FILED

APR 15 1997

SAM ORLICH

AUDITOR LAKE COUNTY

Exhibit "A"