



COMMUNITY TITLE COMPANY

- An Indiana Corporation -
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

#00013520

AFFIDAVIT

STATE OF INDIANA)
) SS.:
COUNTY OF LAKE)

Mildred Crnokrak, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Nicholas Crnokrak died ~~(XXXXXXXXXXXXXXXXXXXXXXXXXXXX)~~ (leaving a will) on NOVEMBER 28, 1995 at V.N.A. HOSPICE CENTER, VALPARAISO, 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: LOT 18- OM BARCLAY VILLAGE, UNIT NO. 3, IN THE TOWN OF MERRILLVILLE, AS PER PLAT THEREOF, RECORDED JUNE 19, 1979 IN PLAT BOOK 50 PAGE 76 AND CORRECTED BY PLAT OF CORRECTION RECORDED AUGUST 13, 1979 IN PLAT BOOK 51 PAGE 18, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA. COMMONLY KNOWN AS: 968 61ST AVENUE, MERRILLVILLE, IN 46410

NOT OFFICIAL!

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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) ~~(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~~ were not sufficient to necessitate payment of ~~decedent's~~ federal state tax.

97035972

97 JUN -5 AM 11:01

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

MAY 29 1997

Further affiant sayeth not.

SAM ORLICH
AUDITOR LAKE COUNTY

Mildred Crnokrak
MILDRED CRNOKRAK

Subscribed and sworn to before me, a Notary Public, this 20TH day of MAY, 19 97.

Jacqueline Ruark
JACQUELINE RUARK Notary Public

My Commission expires:

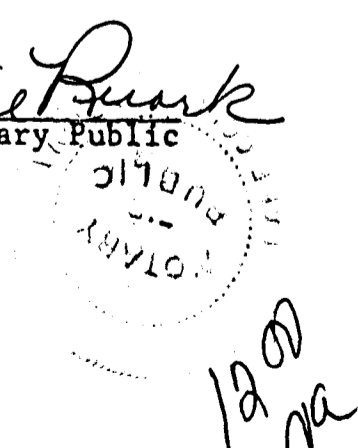
AUGUST 31, 1999

County of Residence:

001837

LAKE

This Instrument prepared by Mildred Crnokrak



1200
na

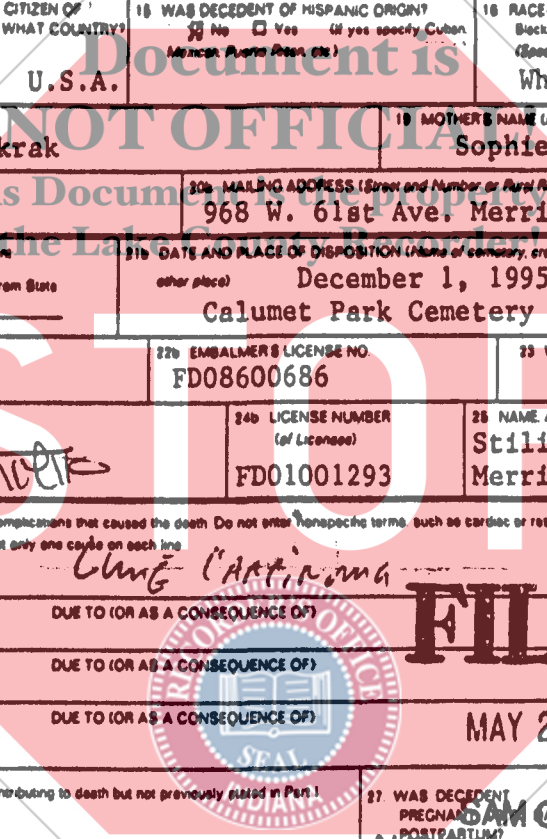
This Document Not Valid
Unless Stamped on Reverse
Side and Embossed With
Raised Seal of Porter County

PORTER COUNTY
CERTIFICATE OF DEATH

Porter County
Health Department
1401 Calumet Avenue
Valparaiso, Indiana 46383

TYPE/PRINT
IN
PERMANENT
BLACK INK

1 DECEASED—NAME (First Middle Last) Nicholas Crnokrak		2 SEX Male	3a TIME OF DEATH 1:45P	3b DATE OF DEATH (Month Day Yr) November 28, 1995
4 SOCIAL SECURITY NUMBER 342-05-2663		5a AGE—Last Birthday (Years) 82	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes
6 DATE OF BIRTH (Mo Day Yr) November 14, 1913		7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL.		
8a WAS DECEDENT A U.S. VETERAN? No	8b YEAR LAST SERVED IN U.S. ARMED FORCES? None	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b FACILITY NAME (If not institution, give street and number) V.N.A. Hospice Center		9c CITY, TOWN OR LOCATION OF DEATH Valparaiso	9d COUNTY OF DEATH Porter	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife, give maiden name) Mildred Milosovich	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Foreman		12b KIND OF BUSINESS/INDUSTRY Wisconsin Steel Division
13a RESIDENCE—STATE IN.	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 968 W. 61st Ave.	
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input 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 only highest grade completed) 8		17b College (1-4 or 5+) 		
18 FATHER'S NAME (First Middle Last) John Crnokrak		19 MOTHER'S NAME (First Middle Maiden Surname) Sophie Kleut		
20a INFORMANT'S NAME (Type/Print) Mildred Crnokrak		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 968 W. 61st Ave. Merrillville, IN 46410		20c Relationship Wife
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) December 1, 1995 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, IN.
22a EMBALMER'S NAME David Semplinski		22b EMBALMER'S LICENSE NO. FD08600686		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Robert Wiatrolik</i>		24b LICENSE NUMBER (of Licensee) FD01001293		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PH3004453 Stililovich & Wiatrolik 7535 Taft St. Merrillville, IN 46410
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. lung carcinoma				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. _____ DUE TO (OR AS A CONSEQUENCE OF) b. _____ DUE TO (OR AS A CONSEQUENCE OF) 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				
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				
27 WAS DECEDENT PREGNANT AT DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28 WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		29b 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>William S. Gasparis MD</i>		29c MEDICAL LICENSE NO. 01037515		29d DATE SIGNED (Month Day Year) 12-1-95
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Gasparis 1400 S. Lake Park Hobart, IN 947-6045				
31 HEALTH OFFICER'S SIGNATURE <i>Gary A. Boboche MD</i>				32 DATE FILED (Month Day Year) December 4, 1995
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.		



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