

FILED

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

OCT 03 1997

SAM ORLICH
AFFIDAVIT **AUDITOR GENERAL**
OF LAKE COUNTY

ELEANOR M. GLINSKI, being first duly sworn upon her oath, deposes and states as follows:

1. That your affiant's husband, namely, EDWARD J. GLINSKI, died on the 18th day of November, 1995.

2. That your affiant and her deceased husband were legally married at the time they acquired title, as husband and wife, to the following described real estate:

Lots 71 and 74, (including that part of vacated Ann St. adjoining the South line of Lot 74, as vacated in Cause No. 17089, Lake Circuit Court) in Young's third Addition, in the City of Crown Point, as per plat thereof, recorded in Miscellaneous Record "A" page 534, in the Office of the Recorder of Lake County, Indiana. 9-97-52 + 5

3. That the marital relationship which existed between your affiant and her deceased husband at the time they acquired title to the real estate described hereinabove, remained in effect and unbroken until the date of Edward J. Glinski's death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all property in which the decedent had an interest, whether real, personal, tangible and mixed, was owned jointly with your affiant with rights of survivorship. That as a result of the marital relationship between your affiant and her deceased husband, neither federal estate taxes nor state inheritance taxes would be due and owing.

Further affiant saith not.

Eleanor M. Glinski
ELEANOR M. GLINSKI

STATE OF INDIANA, COUNTY OF LAKE, SS:

Subscribed and sworn to before me, a Notary Public in and for said County and State this 30th day of SEPTEMBER, 1997.

Karen Kane
Notary Public KAREN KANE

My Commission Expires: 9/12/99
County of Residence of Notary Public: PORTER

This instrument prepared by: John R. Sorbello, attorney at law.

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TICOR TITLE INSURANCE
Crown Point, Indiana

97067206

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

97 OCT 3 AM 9:55
MORNING
PORTER

* 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

State No.

Local No. 2625-95

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

PRECEDENT

PARENTS

INFORMANT

DISPOSITION

USE OF
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1 DECEASED—NAME (First Middle Last) Edward J. Glinski		2 SEX Male	3a TIME OF DEATH 7:00A	3b DATE OF DEATH (Month Day Year) November 18, 1995	
4 SOCIAL SECURITY NUMBER 311-07-0943	5a AGE—Last Birthday (Years) 78	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Month Day Year) APR 11, 1917	
7 BIRTHPLACE (City and State or Foreign Country) Chicago, IL	8a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Present <input type="checkbox"/> ED/Outpatient <input type="checkbox"/> OOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
8b WAS DECEDENT A U.S. VETERAN? No	8c YEAR LAST SERVED IN U.S. ARMED FORCES N/A	9a FACILITY NAME (If not residential give street and number) St. Anthony Medical Center			
9b CITY, TOWN OR LOCATION OF DEATH Crown Point		9c COUNTY OF DEATH Lake			
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Eleanor Marshall	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Fire Fighter		12b KIND OF BUSINESS/INDUSTRY U. S. Steel	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY, TOWN OR LOCATION Crown Point		13d STREET AND NUMBER 139 S. John Street	
13e ZIP CODE 46307	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input 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 (10-12) 8 College (1-4 or 5 +)			
18 FATHER'S NAME (First Middle Last) Alex Bush		19 MOTHER'S NAME (First Middle Maiden Surname) Helen Santor			
20a INFORMANT'S NAME (Type/Print) Eleanor Glinski		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 S. John Street, Crown Point, IN 46307		20c Relationship Wife	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <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) NOV 21, 1995 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana	
22a SUBALTERN'S NAME Marty Andersen		22b EMBALMER'S LICENSE NO. FD01005205	22c WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
23a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		23b LICENSE NUMBER (of Licensee) FD09000013	23c NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83001253 Gelsen Funeral Home, Inc. 109 N East St., Crown Point, IN46307		
24 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. Malignant Cardiac Arrhythmia Delayed Cardiac Arrest					
25 THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH AS FILED WITH THE CLERK OF THE COUNTY OF LAKE, INDIANA, ON NOV 20 1995. DUE TO (OR AS A CONSEQUENCE OF) _____ DUE TO (OR AS A CONSEQUENCE OF) _____					
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Alexander S. Williams, M.D.					
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) No		
29a CERTIFIED BY (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>[Signature]</i>		29c MEDICAL LICENSE NO. 01039302	29d DATE SIGNED (Month Day Year) 11-20-95		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (STEM 20) (Type/Print) Bernardo S. Lucena M. D., 1121 S. Indiana Ave., Crown Point, IN 46307					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>			32 DATE FILED (Month Day Year) November 20, 1995		
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 (Specify)	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.			