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FILED STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA)
COUNTY OF LAKE)
97069009

OCT 09 1997
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SAM ORLICH
AUDITOR LAKE COUNTY

494396 40

AFFIDAVIT OF SURVIVORSHIP

ROSE MARIE BENNER, being first duly sworn upon her oath, deposes and states as follows:

Chicago Tide Insurance Company

1. That your affiant is the daughter of Joseph S. Bala and Angeline Marie Bala.
2. That your affiant's father, namely, JOSEPH S. BALA, died on the 6th day of October, 1990.
3. That Joseph S. Bala and Angeline Marie Bala were legally married at the time they acquired title, as husband and wife, to the following described real estate:

Lot 39 and 40, Block 24, subdivision of that part of the West 3/7ths of the Southwest Quarter of Section 29, Township 37 North, Range 9 West, in the City of East Chicago, as shown in Plat Book 2, page 41, in Lake County, Indiana.
4. That the marital relationship which existed between the affiant's mother and father at the time they acquired title to the real estate described hereinabove, remained in effect and unbroken until the date of Joseph S. Bala's death.
5. That all funeral expenses in connection with the death of said decedent have been paid in full.
6. That all property in which the decedent had an interest, either real, personal, tangible and mixed, was owned jointly with Angeline Marie Bala, with rights of survivorship. That as a result of the marital relationship between the affiant's mother and father, neither federal estate taxes nor state inheritance taxes would be due and owing.

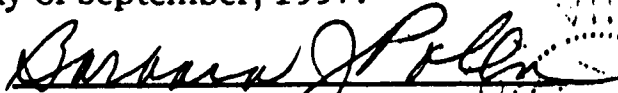
Further affiant saith not.

Rose Marie Benner
ROSE MARIE BENNER

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STATE OF INDIANA, COUNTY OF LAKE, SS:

Subscribed and sworn to before me, a Notary Public in and for
said County and State this 29th day of September, 1997.


Notary Public, Barbara J. Polen



My Commission Expires: 7/16/2001
County of Residence of Notary Public: Lake

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

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 2046-90

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

1. DECEASED—NAME (First Middle Last) JOSEPH S. BALA		2. SEX MALE	3a. TIME OF DEATH M	3b. DATE OF DEATH (Month Day Yr) OCT. 6-1990
4. SOCIAL SECURITY NUMBER 309-14-9004		5a. AGE—Last Birthday (Years) 81	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes
6a. WAS DECEDENT A US VETERAN? YES		6b. YEAR LAST SERVED IN US ARMED FORCES? 1944		7. BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO, IN.
8a. 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				
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME 601 SHEFFIELD			9b. CITY, TOWN, OR LOCATION OF DEATH DYER	9c. COUNTY OF DEATH LAKE
10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) ANGELINE CHLEBEK		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) LATHERER
12b. KIND OF BUSINESS/INDUSTRY SELF-EMPLOYED				
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION EAST CHICAGO	13d. STREET AND NUMBER 4841 WALSH AVE.
13e. ZIP CODE 46312	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) Elementary/Secondary (0-12) 6YRS		College (1-4 or 5+)		
18. FATHER'S NAME (First Middle Last) WALTER BALA			19. MOTHER'S NAME (First Middle, Maiden Surname) ANNA WILK	
20a. INFORMANT'S NAME (Type/Print) ANGELINE BALA		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4841 WALSH AVE, EAST CHICAGO, IN 46312		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) OCT. 9-1990 HOLY CROSS CEMETERY		21c. LOCATION—City or Town, State CALUMET CITY, IL.
22a. EMBALMER'S NAME HENRY BLAKE		22b. EMBALMER'S LICENSE NO. 01019406		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Michael Mysliwy</i>		24b. LICENSE NUMBER (of Licensee) 2005999	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 3001619 MYSLIWY FUNERAL HOME 4902 READING AVE, EAST CHICAGO, IN	
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. Cerebral vascular accident Spontaneous arteriosclerosis DEATH ON FILE WITH THE HEALTH DEPT. LAKE COUNTY				
26. PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I. 10/1/1991				
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)
29a. CERTIFIER (Check only one) <input type="checkbox"/> CLERK AND PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated <input checked="" type="checkbox"/> LAKE COUNTY 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>Fred Adler</i>			29c. MEDICAL LICENSE NO. 01019251	29d. DATE SIGNED (Month, Day, Year) 10/9/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) Fred Adler, M.D.; 800 MacArthur Blvd., Suite 2, Munster, IN 46321				
31. HEALTH OFFICER'S SIGNATURE <i>Fred Adler</i>				32. DATE SIGNED (Month, Day, Year) October 16, 1990
33. MANNER OF DEATH <input 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) October 6, 1990	34b. INJURY (Yes or no)	34c. DESCRIBE HOW INJURY OCCURRED
34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e. 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.		