



# COMMUNITY TITLE COMPANY

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

AFFIDAVIT

## FILED

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

OCT 03 1997

**SAM ORLICH**  
**AUDITOR LAKE COUNTY**

KATHRYN D. PAWLJK, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, THOMAS E. PAWLJK died (without leaving a will) ~~XXXXXXXXXXXXXXXXXX~~ on MARCH 27 19 97 at CROWN POINT, 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 3 IN CLINE MEADOWS UNIT NO. 1, IN THE TOWN OF SCHERERVILLE, AS PER PLAT THEREOF, RECORDED APRIL 26, 1974 IN PLAT BOOK 44 PAGE 55, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.  
COMMONLY KNOWN AS 732 SANDI LANE, SCHERERVILLE, IN. 46375  
UNIT 20 KEY NO. 13-188-3

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) ~~death~~ 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's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Kathryn D. Pawljk  
KATHRYN D. PAWLJK

Subscribed and sworn to before me, a Notary Public, this day of September, 1997.

Betty Jo C. Dennis  
Notary Public, Ind.

My Commission expires:

5-22-99.

County of Residence:

Lexington County, S. C.

000254

This Instrument prepared by PATRICK McMANAMA, ATTORNEY AT LAW

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
97 OCT 10 11:11 AM '97  
MORRIS W. CARTER  
REC'D

1200  
3167

\* ATTENTION ESTATE: The Social Security # is being requested by the 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. ... 066897 .....

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

42603  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

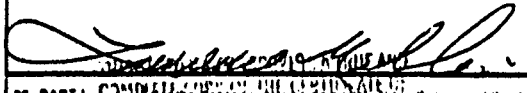
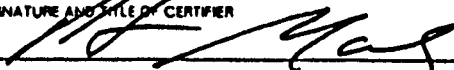
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>Thomas Edward Pawlik</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>4:40 P M</b>	3b DATE OF DEATH (Month Day Year) <b>March 27, 1997</b>	
4 SOCIAL SECURITY NUMBER <b>317-52-9513</b>	5a AGE—Last Birthday (Years) <b>49</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day, Yr) <b>February 6, 1948</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>Hammond, Indiana</b>	8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>				
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1970</b>		8c PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9a FACILITY NAME (If not institution, give street and number) <b>St. Anthony Hospital</b>		9b CITY, TOWN OR LOCATION OF DEATH <b>Crown Point</b>	9c COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Kathryn Lee</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Brick Mason</b>		12b KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Schererville</b>	13d STREET AND NUMBER <b>732 Sandi Lane</b>		
13e ZIP CODE <b>46375</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>White</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) <b>Edward L. Pawlik</b>			
19 MOTHER'S NAME (First Middle Maiden Surname) <b>Virginia Kwiatkowski</b>			20a INFORMANT'S NAME (Type, Print) <b>Kathryn Pawlik</b>		
20b MAKING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>732 Sandi Lane; Schererville, IN 46375</b>		20c Relationship <b>Wife</b>			
21a 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) _____		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>April 1, 1997 Chapel Lawn Memorial Gardens</b>		21c LOCATION—City or Town, State <b>Schererville, Indiana</b>	
22a EMBALMER'S NAME <b>Charles W. Wells</b>		22b EMBALMER'S LICENSE NO. <b>FDO 1042372</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR 		24b LICENSE NUMBER (of Licensee) <b>FDO1006015</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Eagen-Miller Funeral Homes FH83003035 2828 Highway Avenue Highland, Indiana 46322</b>		
26 PART I: COMPLETELY LIST ALL THE DISEASES, INJURIES, OR CONDITIONS THAT CAUSED THE DEATH. Do not enter nonspecific terms, such as cardiac or respiratory. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>CONGESTIVE HEART FAILURE</b>					
DUE TO (OR AS A CONSEQUENCE OF) <b>BACTERIAL ENDORRHOEAL COLITIS</b>					
DUE TO (OR AS A CONSEQUENCE OF) <b>COLIC</b>					
DUE TO (OR AS A CONSEQUENCE OF) <b>COLIC</b>					
DUE TO (OR AS A CONSEQUENCE OF) <b>COLIC</b>					
DATE OF DEATH: <b>MAR 27 1997</b>					
SIGNATURE OF HEALTH OFFICER: <b>Alexander D. ... M.D.</b>					
SIGNATURE OF LANE COUNTY HEALTH COMMISSIONER: _____					
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) <b>No</b>		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"/> 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 		29c MEDICAL LICENSE NO. <b>01030831</b>	29d DATE SIGNED (Month, Day, Year) <b>3/28/97</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) <b>PETER G. MAVRELIS, M.D., 8875 Broadway, Merrillville, IN 46410</b>					
31 HEALTH OFFICER'S SIGNATURE <b>Alexander D. ... M.D.</b>				32 DATE FILED (Month, Day, Year) <b>March 31, 1997</b>	
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
34a 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.			