Chicago Title Insurance Company

4042 Lake Fall
496672 20

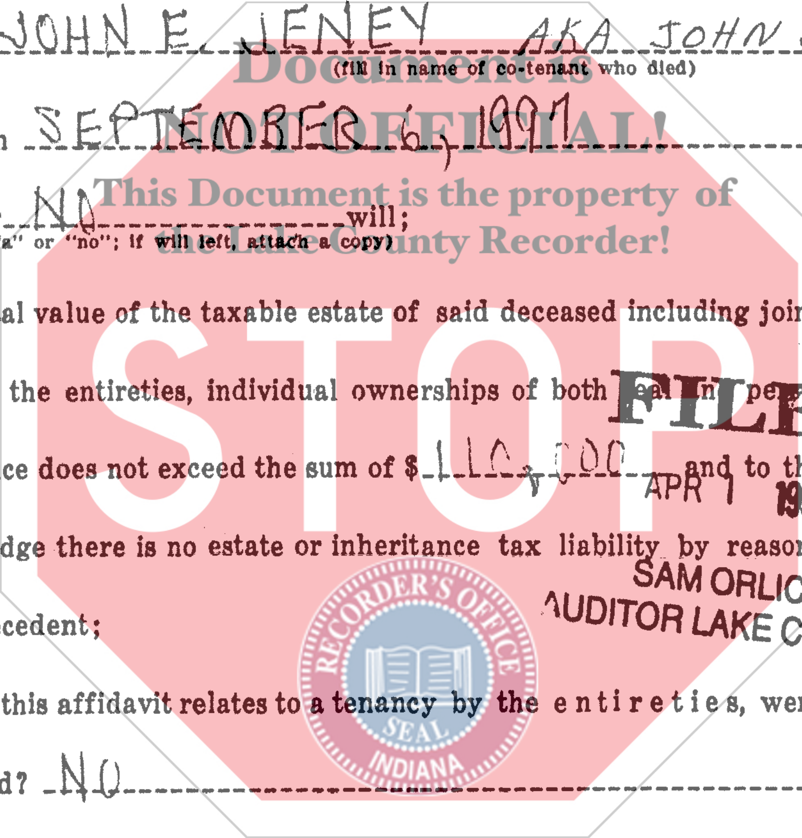
SURVIVORSHIP AFFIDAVIT

STATE OF Indiana
COUNTY OF Lake } S. S.

On this MARch 28, 1998 (insert date) before me personally appeared FRANCES A. JENEY

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;
2. Affiant is OWNER (state interest of affiant in the above premises as "owner," "son of owner," etc.);
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by JOHN E JENEY and FRANCES A. JENEY;
4. Said JOHN E. JENEY AKA JOHN JENEY (fill in name of co-tenant who died) died on SEPTEMBER 6, 1997 leaving NO will; (insert "a" or "no"; if will left, attach a copy)
5. The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of $110,000 and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of said decedent;
6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NO (If answer is "Yes," identify the divorce proceedings:);
7. Affiant's relationship to the deceased was WIFE.



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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
98 APR -2

FILED
APR 1 1998
SAM ORLICH
AUDITOR LAKE COUNTY

Signature: Frances A. Jeney
FRANCES A. JENEY
Address: 8010 Jefferson Ave.
Munster IN 46321

Subscribed and sworn to before me by the affiant this March 13, 1998 (insert date)

CAROL A. NAGY
Notary Public
LAKE County, RESIDENT
My Commission Expires 4-13-98

This instrument prepared by FRANCES A. JENEY

Lot 35 Winner Parkway addition, Munster, Plat Book 32, Page 4 Lake Co. In. Key # 18-28-190-35

Chicago Title Insurance Company

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12.00 KR CT

* 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.

Local No. 1224-97

201609

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): JOHN JENEY

2 SEX: MALE

3a TIME OF DEATH: 7:22 A.M

3b DATE OF DEATH (Month, Day, Yr): SEPTEMBER 6, 1997

4 *SOCIAL SECURITY NUMBER: 316-24-5225

5a AGE—Last Birthday (Years): 67

5b UNDER 1 YEAR Months Days

5c UNDER 1 DAY Hours Minutes

6 DATE OF BIRTH (Mo, Day, Yr): July 23,1930

7 BIRTHPLACE (City and State or Foreign Country): Hammond,IN

8a WAS DECEDENT A U.S. VETERAN?: Yes

8b YEAR LAST SERVED IN U.S. ARMED FORCES?: N.A.

9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b FACILITY NAME (If not institution, give street and number): THE COMMUNITY HOSPITAL

9c CITY, TOWN, OR LOCATION OF DEATH: MUNSTER

9d COUNTY OF DEATH: LAKE

10 MARITAL STATUS (Specify): Married

11 SURVIVING SPOUSE (If wife, give maiden name): Frances Hric

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Tinner

12b KIND OF BUSINESS/INDUSTRY: American Maize

13a RESIDENCE—STATE: IN

13b COUNTY: Lake

13c CITY, TOWN, OR LOCATION: Munster

13d STREET AND NUMBER: 8010 Jefferson

13e ZIP CODE: 46321

13f INSIDE CITY LIMITS: ☐ No ☒ Yes

13g ON A FARM?: ☒ No ☐ Yes

14 CITIZEN OF WHAT COUNTRY?: U.S.A.

15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 12; College (1-4 or 5+): 2

PARENTS

18 FATHER'S NAME (First, Middle, Last): John Stephen Jeney

19 MOTHER'S NAME (First, Middle, Maiden Surname): Annabell Maria Sotak

INFORMANT

20a INFORMANT'S NAME (Type/Print): Frances Jeney

20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8010 Jefferson Munster,IN 46321

20c Relationship: Wife

DISPOSITION

21a METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)

21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 9,1997 NW IN Crematory

21c LOCATION—City or Town, State: Crown Point,IN

22a EMBALMER'S NAME: ----

22b EMBALMER'S LICENSE NO: ----

23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR: [signature]

24b LICENSE NUMBER (of Licensee): 1021590

25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#3004968 8415 Calumet Munster,IN 46321

CAUSE OF DEATH

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a Cardio Pulmonary aRrest — Found at Home

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: b DUE TO (OR AS A CONSEQUENCE OF): / DUE TO (OR AS A CONSEQUENCE OF): / DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death:

PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I: Chronic Bronchial Asthma

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): ---

CERTIFIER

29a CERTIFIER (Check only one):
☒ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☐ 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.
☐ 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: [signature] MD

29c MEDICAL LICENSE NO: 01027057

29d DATE SIGNED (Month, Day, Year): 9/8/97

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): RICHARD L. GOOD, M.D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER SIGNATURE: Alexander Williams, MD

32 DATE FILED (Month, Day, Year): September 8, 1997

FILED APR 1 1998 SAM ORLICH AUDITOR LAKE COUNTY

33 MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.

FEB 06 1998

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