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98026221

STATE OF INDIANA
LAKE COUNTY
RECORDER

90 APR 15 AM 9:00

FILED

APR 14 1998

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

SAM ORLICH
AUDITOR LAKE COUNTY

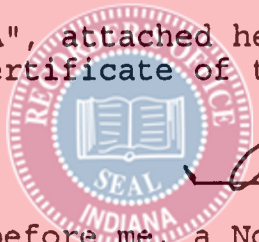
A F F I D A V I T

Ann M. Berzinis, being first duly sworn upon her oath, states:

1. That she resides at 7032 Tapper in Hammond, Lake County, Indiana.
2. That she is the surviving widow Frank (E.) Berzinis, who died a resident of Hammond, Lake County, Indiana on February 24, 1988.
3. That she is the surviving and exclusive owner of the following parcel of real property, which is located at 7032 Tapper in Hammond, Lake County, Indiana and legally described as:

Lots 17 and 18 in Block Three in the Calumet
 Boulevard Addition to Hammond, as per plat
 thereof, recorded in the Plat Book 18,
 Page 31 in the Office of the Recorder of
 Lake County, Indiana

4. That Exhibit "A", attached hereto, is a true, correct and authentic copy of the death certificate of the aforesaid Frank (E.) Berzinis.



Ann M. Berzinis

SUBSCRIBED and SWORN to before me, a Notary Public, this 31st day of March, 1998.

[Signature]

My Commission Expires: February 6, 1999
County of Residence : Lake

This Document Prepared By: Kenneth M. Wilk, Attorney at Law,
3235 - 45th Street, Highland, IN



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1200
2964

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

THIS THE FOLLOWING IS A TRUE AND CORRECT COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 173

CERTIFICATE OF DEATH

DATE ISSUED FEB 27 1998 Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Frank Berzinis		2 SEX Male	3a TIME OF DEATH 5:44 am	3b DATE OF DEATH (Month Day Yr) February 24, 1998
4 SOCIAL SECURITY NUMBER 306-01-7618	5a AGE—Last Birthday (Year) 82	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) April 4, 1915
7 BIRTHPLACE (City and State or Foreign Country) East Chicago, IN	8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
9b FACILITY NAME (If not institution give street and number) St. Margaret Mercy - North Campus		9c CITY TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Ann m. Vojtas	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Assistant Stillman		12b KIND OF BUSINESS/INDUSTRY ARCO
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Hammond		13d STREET AND NUMBER 7032 Tapper Ave.,
13e ZIP CODE 46324	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 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) 12 College (14 or 16) 0		18 FATHER'S NAME (First Middle Last) Frank Berzinis		
19 MOTHER'S NAME (First Middle Maiden Surname) Katherine Siurkus			20a INFORMANT'S NAME (Type, Print) Ann M. Berzinis	
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7032 Tapper Ave., Hammond, IN 46324		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) February 26, 1998 St. Joseph Cemetery		21c LOCATION—City or Town, State Hammond, IN
22a EMBALMER'S NAME Henry J. Blake		22b EMBALMER'S LICENSE NO. FOO1019406		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Edwin B. Lukaszewski</i>		24b LICENSE NUMBER (of Licensee) FOO1000857		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME LaHayne Funeral Home, Inc., FH1940000 6955 Southeastern Ave., Hammond, IN 46324
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. Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Upper gastrointestinal hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF)				
b. <i>Esophageal varices</i> DUE TO (OR AS A CONSEQUENCE OF)				
c. <i>Arteriosclerosis of heart</i> DUE TO (OR AS A CONSEQUENCE OF)				
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) 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 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) as stated.				
29b SIGNATURE AND TITLE OF CERTIFIER <i>James B. Wolshorn</i>		29c HEALTH OFFICER'S LICENSE NO. 01027487		29d DATE SIGNED (Month Day Year) 2/25/98
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) James B. Wolshorn, 5500 Johnson, Hammond, IN 46324				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Oremuda M.D.</i>				32 DATE FILED (Month Day Year) February 27, 1998
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)	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 000753		

