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98 JUN 10 AM 9:59

MORRIS W. CARTER  
RECORDER

**Chicago Title Insurance Company**

H497840 LD

**SURVIVORSHIP AFFIDAVIT**

On this JUNE 9, 1998 before me personally appeared  
(insert date)

Ronald C. Markovich

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

- Affiant resides at the address given below affiant's signature;
- Affiant is Owner;  
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
- Said premises were formerly owned as joint tenants or as tenants by the entireties by Ronald C. Markovich and Alexandra Markovich;
- Said Alexandra Markovich  
(fill in name of co-tenant who died)  
died on January 28, 1991  
leaving No will;  
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:  
LOTS 32, 33, AND 34, BLOCK 25, UNIT 7 OF WOODMAR, IN THE CITY OF  
AS SHOWN IN PLAT BOOK 16, PAGE 34, IN LAKE COUNTY, INDIANA.

6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent?  Yes  No

If yes, then estimated taxes due are \$ \_\_\_\_\_

The taxes due are  paid or  unpaid.

**FILED**

JUN 17 1998

SAM ORLICH  
RECORDER LAKE COUNTY

13.00  
c.m.  
CT

001327

Chicago Title Insurance Company

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:

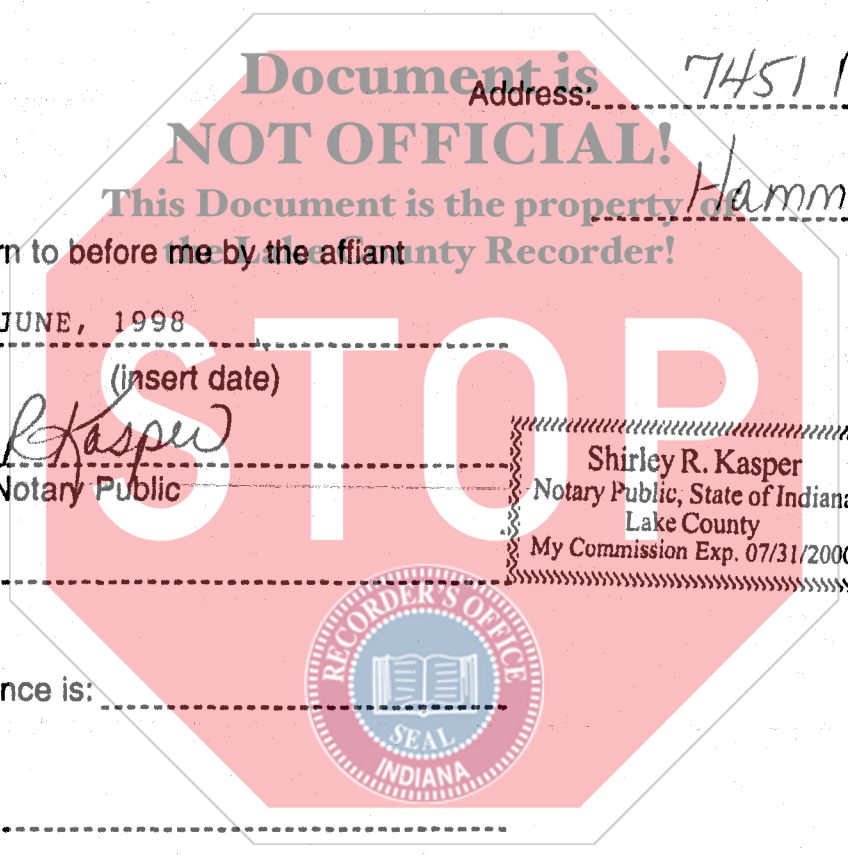
.....);

8. Affiant's relationship to the deceased was Spouse

Signature: Ronald C. Markovich

Printed Name Ronald C. Markovich

Address: 7451 Magun Avenue  
Hammond In 46324



Subscribed and sworn to before me by the affiant

this 9TH DAY OF JUNE, 1998  
(insert date)

Shirley R. Kasper  
Notary Public

Shirley R. Kasper  
Notary Public, State of Indiana  
Lake County  
My Commission Exp. 07/31/2000

Printed Name .....

My County of Residence is: .....

In the State of .....

My Commission Expires .....

This instrument prepared by Ronald C. Markovich

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

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

Local No. 83

Jan 30, 1991 *Franklin D. Remuda M.D.*  
Date Issued Hammond Health Commissioner

H497840

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) <b>Alexandra M. Markovich</b>		2 SEX <b>Female</b>	3a TIME OF DEATH <b>3:28 p.m.</b>	3b DATE OF DEATH (Month, Day, Yr) <b>January 28, 1991</b>	
4 SOCIAL SECURITY NUMBER <b>310-52-3202</b>	5a AGE—Last Birthday (Years) <b>44</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>July 29, 1946</b>	
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>—</b>	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) <b>St. Margaret Hospital</b>		9c CITY/TOWN OR LOCATION OF DEATH <b>Hammond</b>	9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>Ronald C. Markovich</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Legal Secretary</b>	12b KIND OF BUSINESS/INDUSTRY <b>Law Offices</b>		
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY/TOWN OR LOCATION <b>Hammond</b>	13d STREET AND NUMBER <b>7451 Magoun Avenue</b>		
13e ZIP CODE <b>46324</b>	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? <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 (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>					
18 FATHER'S NAME (First Middle Last) <b>Edward Sekulski</b>		19 MOTHER'S NAME (First Middle Maiden Surname) <b>Josephine Jackowski</b>			
20a INFORMANT'S NAME (Type/Print) <b>Ronald C. Markovich</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7451 Magoun Avenue, Hammond, IN 46324</b>	20c Relationship <b>Husband</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>January 31, 1991! Holy Cross Cemetery</b>		21c LOCATION—City or Town, State <b>Calumet City, Illinois</b>	
22a EMBALMER'S NAME <b>Larry D. Anthony</b>		22b EMBALMER'S LICENSE NO. <b>01001447</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		24b LICENSE NUMBER (of Licensee) <b>01001447</b>	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Anthony &amp; Dziadowicz FH 83002916 9445 Calumet, Munster, In 46321</b>		
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 <b>Metastatic Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF)					
Conditions if any which gave rise to the immediate cause stating the underlying cause last b DUE TO (OR AS A CONSEQUENCE OF)					
c DUE TO (OR AS A CONSEQUENCE OF)					
d					
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) <b>No</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>		
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) and manner as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>W. M. ...</i>			
29c MEDICAL LICENSE NO. <b>33507</b>		29d DATE SIGNED (Month, Day, Year) <b>1-29-91 Jan. 29, 1991</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>H. Mishoulam, M.D. 9725 Prairie Avenue, Highland, Indiana 46322</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>				32 DATE FILED (Month, Day, Year) <b>JAN 30 1991</b>	
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 MOTOH VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc			

