Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA
COUNTY OF LAKE } S. S.

98052187

On this June 25, 1998 (insert date) before me personally appeared

Cathleen A. Mihajlovich-Freie

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 Robert W. Freie and Cathleen A. Mihajlovich-Freie;

4. Said Robert W. Freie (fill in name of co-tenant who died)
died on August 25, 1994
leaving No (insert "a" or "no"; if will left, attach a copy) will;

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 $120,000.00 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.

Signature:

Address: 36 Lilac Court
Schererville, IN 46375

FILED
JUL 09 1998
SAM ORLICH
AUDITOR LAKE COUNTY

Subscribed and sworn to before me by the affiant this June 25, 1998 (insert date)

Katherine E. Adams
Notary Public

Katherine E. Adams
My Commission Expires 12-13-2000

12.00
CM
FA

This instrument prepared by Cathleen A. Mihajlovich-Freie

(1) F24905

000736

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ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. 2643-94 — **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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
ROBERT WILLIAM OSCAR FREIE	MALE	4:10 P.M	AUGUST 25, 1994

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr)	7. BIRTHPLACE (City and State or Foreign Country)
486 - 40 - 3074	55			Dec. 3, 1938	St Louis, Missouri

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1960	HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Cathleen A.Mihajlovich	Self-Employed Truck Driver	Trucking Business

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Schererville	36 Lilac Court

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46375	☐ No ☒ Yes	☒ No ☐ Yes	U. S. A.	☒ No ☐ Yes	White	Elementary/Secondary (0-12): n/a	College (1-4 or 5 +)

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
William Freie	Elsie Pruessner

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Cathleen Mihajlovich-Freie	36 Lilac Crt., Schererville, IN 46375	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	August 29, 1994 Calumet Park Cemetery	Merrillville, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
Charles W. Wells	FD0104372	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
David J. Pastrick	FD08800012	Oleska-Pastrick Funeral Home FH155 3934 Elm St., East Chicago, IN 46312

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.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Congestive Heart Failure	2 years
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. DUE TO (OR AS A CONSEQUENCE OF): Aortic Valvular Disease	3 years
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

Alexander D. Williams M.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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	Yes	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 [illegible] 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 [illegible] investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

SAM ORLICH AUDITOR LAKE COUNTY

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
A. Gandhi	29887	AUGUST 26, 1994

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)	31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
DR. ARVIND GANDHI, M. D. 9122 COLUMBIA AVENUE MUNSTER, INDIANA 46321	Alexander D. Williams M.D	August 30, 1994

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				

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.

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