ESTATE AFFIDAVIT

FA: FA- 25182

Address: 4717 ASH STREET
HAMMOND, IN

Legal Description:

LOT 49 IN BLOCK 1, IN BIRKHOFF's ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 5 PAGE 7, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

HOLD FOR FIRST AMERICAN TITLE

98070998

98 SEP -8 AM 10:

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

MORRIS A. SIMON

KATHLEEN POTOSKY, Affiant, states that:

1. GERALD S. POTOSKY, deceased, died on the 8 day of May, 1998.

2. Affiant is: ✓ the surviving spouse of the deceased,

___ the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: ___ leaving a will which has been probated;

___ leaving a will which has not been probated;

✓ leaving no will;

4. The deceased and Affiant were married on the 16 day of October, 1965; and were never divorced.
(This item applies only to the surviving spouse.)

5. ✓ All expenses of the last illness and funeral of the deceased have been paid;

6. ✓ All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. ✓ There are no claims against the estate of the decedent.

FILED
SEP 8 1998
SAM ORLICH
AUDITOR LAKE COUNTY

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

SEPTEMBER 2, 1998
Date

Kathleen Potosky
Signature of Affiant

KATHLEEN POTOSKY
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 2nd day of SEPTEMBER, 19 98.

CORINA CASTEL RAMOS
Printed Name of Notary

Signature of Notary

My Commission expires: 5/16/01

My County of Residence is: PORTER

Prepared By: KATHLEEN POTOSKY

F25182

000602

12 pgs

25 x

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

Local No. 380

E-Submit

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

MAY 14 1998
Date Issued

Hammond Health Commissioner

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEDENT-NAME (First Middle Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month Day Yr)
Gerald Stanley Potosky	Male	11:15PM	May 8, 1998

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)
303-42-2044	59			September 10, 1938	East Chicago, IN 46312

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	1963	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
7234 New Jersey	Hammond	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	Kathleen Lobonc	Auto painter	Auto repair

13a. RESIDENCE - STATE	13b. COUNTY	13c. CITY TOWN OR LOCATION	13d. STREET AND NUMBER
IN	Lake	Hammond	7234 New Jersey Avenue

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN?	16. RACE - American Indian Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46323	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	White	Elementary/Secondary (0-12): 12	College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Frank Potosky	Mary Rossa

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
Kathleen Potosky	7234 New Jersey Avenue, Hammond, IN 46323	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 ☐ Removal from State ☐ Donation ☐ Other (Specify)	May 12, 1998 St. Joseph Cemetery	Hammond, IN

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
James W. Gholston	1004194	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
George J. Johnson	FD0890006	3002869 Virgil Huber Funeral Home 7051 Kennedy Av., Hammond, IN 46323

CAUSE OF DEATH

26. PART I Enter the disease 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. Lymphoma	
	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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No	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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month Day Year)
R Drasga	01031484	5/11/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print)
Ray Drasga M.D., 8127 Merrillville Rd., Merrillville, IN 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month Day Year)
Franklin D. Brennan M.D.	May 14, 1998

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			No	

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.
	No

SDH06-004 State Form 10110-04 (R4 / 3-93) DEATHCER/PD 1

25×