FA- F27697

HOLD FOR FIRST AMERICAN TITLE

Property Address: 4621 Henry avenue
Hammond, IN 46327

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99029594

99 APR -7 AM 10:36

MONNIE V. CATE
RECORDER

FILED

APR 07 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

If this Affidavit is to be recorded, the legal description of said property will be attached.

ESTATE AFFIDAVIT

WANDA J. ENGLE, Affiant, states that:

1. HELEN PROKOCKI, deceased, died on the 23 day of July, 1982;

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

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

3. The deceased died: X 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 ___ day of ___, 19___; and were never divorced. (This item applies only to the surviving spouse.)

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

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

7. X There are no claims against the estate of the decendent.;

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

03/29/99
Date

X Wanda J Engle
Signature of Affiant
Wanda J. Engle
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 29 day of March, 1999.

Corina Castel Ramos
Printed Name of Notary

Signature of Notary

My Commission expires: 5/16/01

My County of Residence is: Porter

000522

FA 12-254

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

July 24,1992
Date Issued — Hammond Health Commissioner

Local No. 653

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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)
HELEN	PROKOCKI	Female	3:30 A M	July 23, 1992

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)
306-10-9750	83			May 4, 1909	Philadelphia, PA

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)
No	—	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
4621 Henry Avenue	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
Widowed	None	Sales Clerk	Department Store

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	Hammond	4621 Henry Avenue

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)	
						Elementary/Secondary (0-12)	College (1-4 or 5+)
46327	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	10	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
Jacob Augustyn	Mary Skop

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
Wanda Engle	4621 Henry Ave., Hammond, IN 46327	Daughter

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)	July 25, 1992 Oakland Memory Lanes Crematory	Dolton, Illinois

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
Keith D. Anthony	01011911	☐ No ☒ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Keith D. Anthony	01011911	Anthony & Dziadowicz F.H. 83002835 4404 Cameron Ave., Hammond, IN. 46327

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 Metastatic Cancer of the breast	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): 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	—

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)
S. D. Gallani, M.D.	27970	July 23, 1992

HEALTH OFFICER

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
S. D. Gallani, M.D. 9116 Columbia Avenue, Munster, Indiana 46321

31 HEALTH OFFICER'S SIGNATURE — Franklin D. Miranda M.D.

32 DATE FILED (Month, Day, Year): July 24, 1992

CORONER USE ONLY

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.