



COMMUNITY TITLE COMPANY

- An Indiana Corporation -
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

AFFIDAVIT

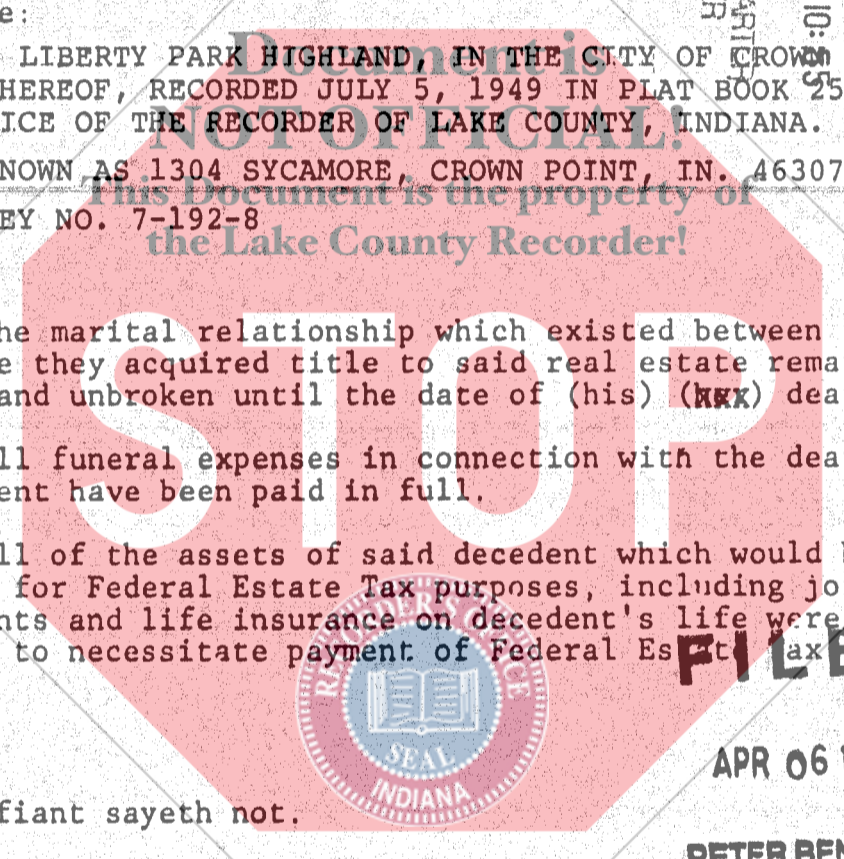
99030040

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

ANNIE BORAK, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, JOVAN BORAK died (without leaving a will) ~~XXXXXXXXXXXX~~ on August 19 97 at St. Margaret Hospital, Hammond, Indiana
2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
LOT 183 IN LIBERTY PARK HIGHLAND, IN THE CITY OF CROWN POINT AS PER PLAT THEREOF, RECORDED JULY 5, 1949 IN PLAT BOOK 25 PAGE 8, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.
COMMONLY KNOWN AS 1304 SYCAMORE, CROWN POINT, IN. 46307
UNIT 3 KEY NO. 7-192-8

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
RECORDER
99 APR - 8 AM 10:25



3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (~~her~~) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate tax.

FILED

APR 06 1999

Further affiant sayeth not.

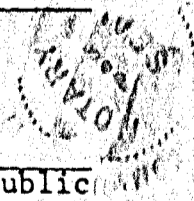
**PETER BENJAMIN
LAKE COUNTY AUDITOR**

Annie Borak
ANNIE BORAK

Subscribed and sworn to before me, a Notary Public, this 31st day of March, 19 99.

COMMUNITY TITLE COMPANY
FILE NO 2 17566

Patricia Ludington
Notary Public



My Commission expires:

**PATRICIA LUDINGTON
NOTARY PUBLIC, STATE OF INDIANA
COUNTY OF LAKE
MY COMMISSION EXPIRES 04-15-08**

County of Residence:

This Instrument prepared by PATRICK McMANAMA, ATTORNEY AT LAW
ID 9534-45

000294

COMM 3/31/99
117

* 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
CERTIFICATE OF DEATH

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

Local No. 663

DATE ISSUED AUG. 21, 1997
Hammond Health Commissioner

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) Jovan Borak		2 SEX Male		3a TIME OF DEATH 12:45 A.M.		3b DATE OF DEATH (Month, Day, Yr) August 21, 1997	
4 SOCIAL SECURITY NUMBER 474 - 38- 1067		5a AGE—Last Birthday (Years) 78		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo, Day, Yr) Jan. 4, 1919		7 BIRTHPLACE (City and State or Foreign Country) Yugoslavia					
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		8c 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			
9a FACILITY NAME (If not institution, give street and number) St. Margaret (Intensiva) Hospital				9b CITY, TOWN, OR LOCATION OF DEATH Hammond		9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Annie		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker		12b KIND OF BUSINESS/INDUSTRY Inland Steel	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Crown Point		13d STREET AND NUMBER 1304 Sycamore Street	
13e ZIP CODE 46307		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? U.S.A.		15 WAS DECEDENT OF HISPANIC ORIGIN? <input 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 (1-4 or 5+) 					
18 FATHER'S NAME (First, Middle, Last) Pajo Borak				19 MOTHER'S NAME (First, Middle, Maiden Surname) Milica (last name not available)			
20a INFORMANT'S NAME (Type/Print) Annie Borak		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Sycamore St., Crown Point, In 46307				20c Relationship Wife	
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) August 23, 1997 Calumet Park Cemetery				21c LOCATION—City or Town, State Merrillville Indiana	
22a EMBALMER'S NAME David W. Semplinski		22b EMBALMER'S LICENSE NO. FDC 8600686		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Jovan Savich</i>		24b LICENSE NUMBER (of Licensee) FD08601292		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home, 10101 Broadway Crown Point, IN 46307 FDH83002445			
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 HYPTENSION AND APNEA 10 MINUTES b CHRONIC RESPIRATORY FAILURE 3 MONTHS c SEPSIS 2 MONTHS d Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last							
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I HODGKINS LYMPHOMA							
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) and manner as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>Rhonda MD</i>		29c MEDICAL LICENSE NO. 010402940		29d DATE SIGNED (Month, Day, Year) AUG 25 1997	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Nisheeth Gupta 9250 Columbia Avenue Munster, IN 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Brumada M.D.</i>						32 DATE FILED (Month, Day, Year) August 27, 1997	
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.					