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STATE OF INDIANA )  
COUNTY OF LAKE

99066563

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

99 AUG 10 AM 9:54

IN THE MATTER OF THE ESTATE OF BERNEICE S. BROWN, Deceased  
(a/k/a Berneice Stella Brown - a/k/a Stella Brown)

MORRIS W. CARTER  
RECORDER

AFFIDAVIT OF HEIRSHIP

Comes now Winifred B. Ratajczak, being duly sworn upon her oath and states as follows:

That she is the daughter of the decedent, Berneice S. Brown, deceased, who died testate, a resident of Lake, County, Indiana on August 1, 1996, the decedent's Will having been filed of record in Estate Docket 45-DO2 9903 ES 37 in the office of the Clerk of Lake County, Indiana.

That she was the owner of the following real estate located in Lake County, Indiana:

Lot 11, Block 1, in Park Manor Third Addition to Griffith, as shown in Plat Book 30, page 30, in Lake County, Indiana (703 N. Lindberg, Griffith, IN)  
Key # 26-203-11

That pursuant to the terms and provisions of the decedent's Last Will and Testament, her residuary estate passes to the following heirs at law:

|                                   |        |   |
|-----------------------------------|--------|---|
| Winifred B. Ratajczak<br>Daughter | 2/3rds | 7630 Montana Ave.<br>Hammond, IN 46323              |
| John T. Ratajczak<br>Grandson     | 1/18th | 7101 Kansas Ave.<br>Hammond, IN 46323               |
| Randi M. Pelczar<br>Granddaughter | 1/18th | 275 Woodland Lane<br>Hobart, IN 46342               |
| Diane M. Fogarty<br>Granddaughter | 1/18th | 1012 N. Dwigins<br>Griffith, IN 46319               |
| Sharon V. Lucich<br>Granddaughter | 1/18th | 7202 Lakeside Woods Drive<br>Indianapolis, IN 46278 |

FILED

AUG 09 1999

PETER BENJAMIN  
LAKE COUNTY AUDITOR

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Michael P. Ratajczak 1/18th  
Grandson

7630 Montana Ave.  
Hammond, IN 46323

Laurel S. Aguilera 1/18th  
Granddaughter

703 N. Lindberg St.  
Griffith, IN 46319

That the statements made in this affidavit are true and complete insofar as the affiant knows and are made for the purpose of establishing the heirship of Berneice S. Brown, deceased.

Document is  
NOT OFFICIAL

This Document is the property of  
the Lake County Recorder!

*Winifred B. Ratajczak*

Winifred B. Ratajczak  
Affiant

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

STOP

Subscribed and sworn to before me, a Notary Public, in and for said County and State, this 4<sup>th</sup> day of August, 1996.



*Kathryn M. Murphy*  
KATHRYN M. MURPHY  
Notary Public

My Commission Expires: 4-27-2000

County of Residence: Lake

**This Document Prepared By:**

JOHN F. HILBRICH  
HILBRICH, CUNNINGHAM & SCHWERD  
2637 - 45th Street  
Highland, IN 46322  
Phone: (219) 924-2427



\* 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

State No. ....

Local No. 2498-96  
41415

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1 DECEASED—NAME (First, Middle, Last)<br><b>Berneice S. Brown</b>  |  | 2. SEX<br><b>Female</b>  |  | 3a TIME OF DEATH<br><b>5:30P<sub>M</sub></b>  |  | 3b. DATE OF DEATH (Month, Day, Yr)<br><b>August 1, 1996</b>   |  |   |  |
| 4. *SOCIAL SECURITY NUMBER<br><b>309-18-3921</b>   |  | 5a AGE—Last Birthday (Years)<br><b>89</b>  |  | 5b UNDER 1 YEAR<br>Months Days  |  | 5c UNDER 1 DAY<br>Hours Minutes   |  |   |  |
| 6. DATE OF BIRTH (Mo, Day, Yr)<br><b>July 8, 1906</b>  |  | 7 BIRTHPLACE (City and State or Foreign Country)<br><b>East Chicago, IN.</b>               |  |   |  |   |  |   |  |
| 8a WAS DECEDENT A U.S. VETERAN?<br><b>No</b>   |  | 8b YEAR LAST SERVED IN U.S. ARMED FORCES?<br><b>N/A</b>                                    |  | 9a PLACE OF DEATH (Check only one See instructions)   |  |   |  |   |  |
| HOSPITAL <input type="checkbox"/> Inpatient  |  |  |  | OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |
| <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  |  |  | <input type="checkbox"/> Residence  |  |   |  |   |  |
| 9b FACILITY NAME (If not institution, give street and number)<br><b>Hammond Clinic</b>   |  |  |  | 9c CITY, TOWN, OR LOCATION OF DEATH<br><b>Munster</b>   |  | 9d COUNTY OF DEATH<br><b>Lake</b>   |  |   |  |
| 10. MARITAL STATUS (Specify)<br><b>Widowed</b>   |  | 11 SURVIVING SPOUSE (If wife, give maiden name)<br><b>None</b>                             |  | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired)<br><b>Chief Operator</b>          |  | 12b. KIND OF BUSINESS/INDUSTRY<br><b>Telephone</b>  |  |   |  |
| 13a RESIDENCE—STATE<br><b>IN</b>   |  | 13b COUNTY<br><b>Lake</b>  |  | 13c CITY, TOWN, OR LOCATION<br><b>Griffith</b>  |  | 13d STREET AND NUMBER<br><b>703 N. Lindberg</b>   |  |   |  |
| 13e ZIP CODE<br><b>46319</b>   |  | 13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes |  | 14 CITIZEN OF WHAT COUNTRY?<br><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.) |  |   |  |
| 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes   |  | 16 RACE—American Indian, Black, White, etc. (Specify)<br><b>White</b>                      |  | 17 DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>     |  |   |  |   |  |
| 18 FATHER'S NAME (First, Middle, Last)<br><b>Jonas Zwinklis</b>  |  |  |  | 19 MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ursula Shiligai</b>  |  |   |  |   |  |
| 20a. INFORMANT'S NAME (Type/Print)<br><b>Winifred Ratajczak</b>  |  |  |  | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7630 Montana Hammond IN 46323</b>      |  | 20c Relationship<br><b>Daughter</b>   |  |   |  |
| 21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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)<br><b>August 5, 1996<br/>Calumet Park Cemetery</b>        |  | 21c LOCATION—City or Town, State<br><b>Merrillville, IN</b>   |  |   |  |
| 22a EMBALMER'S NAME<br><b>James Porras</b>   |  |  |  | 22b EMBALMER'S LICENSE NO<br><b>1045964</b>   |  | 23 WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  |  |   |  |
| 24a SIGNATURE OF FUNERAL DIRECTOR<br><i>Brian Bu</i>   |  |  |  | 24b LICENSE NUMBER (of Licensee)<br><b>8601763</b>  |  | 25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME<br><b>Burns-Kish Funeral Home 8800135<br/>921 W. 45th Griffith IN 46319</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)<br><b>Ischemic Bowel</b>   |  |  |  |   |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF)   |  |  |  |   |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF)   |  |  |  |   |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF)   |  |  |  |   |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF)   |  |  |  |   |  |   |  |   |  |
| 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  |  |  |  |   |  |   |  |   |  |
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)<br><b>No</b>   |  |  |  | 28a WAS AN AUTOPSY PERFORMED? (Yes or no)<br><b>No</b>  |  | 28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)<br><b>NO</b>   |  |   |  |
| 29a CERTIFIER (Check only one)<br><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<br><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<br><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<br><i>[Signature]</i>  |  |   |  | 29c MEDICAL LICENSE NO<br><b>01035923</b> |  |
| 29d DATE SIGNED (Month, Day, Year)<br><b>8/5/96</b>  |  |  |  | 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br><b>J.A. Cahalan 705 Calumet Ave Munster IN 46321</b> |  |   |  |   |  |
| 31 HEALTH OFFICER'S SIGNATURE<br><i>[Signature]</i>  |  |  |  | 32 DATE FILED (Month, Day, Year)<br><b>AUG 09 1996</b>  |  |   |  |   |  |
| 33 MANNER OF DEATH<br><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<br><b>AUG 07 1996</b>   |  | 34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)       |  |   |  | 34f LOCATION (Street and Number or Rural Route Number, City & Town, State)  |  |   |  |
| 34g DATE PRONOUNCED DEAD (Month, Day, Year)  |  |  |  | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.<br><b>000631</b>                              |  |   |  |   |  |

DECEDENT

PARENTS

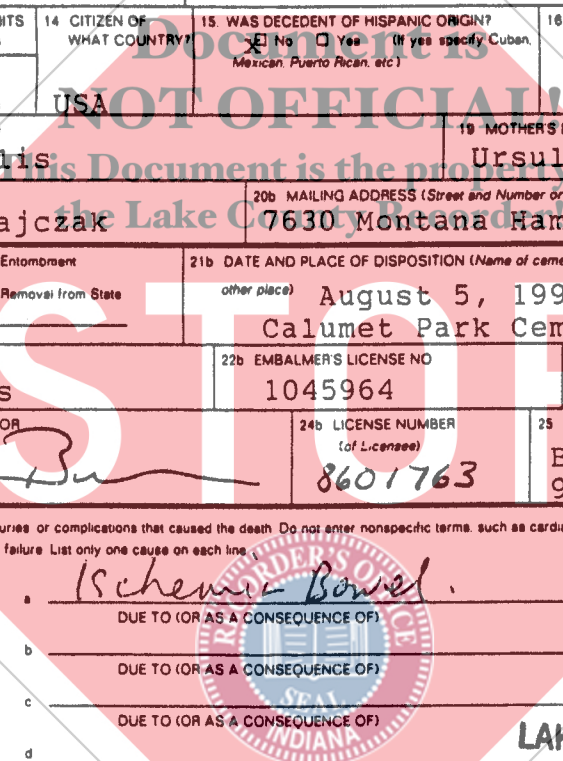
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER



**FILED**

**AUG 09 1996**

**PETER BENJAMIN  
LAKE COUNTY AUDITOR**