



Chicago Title Insurance Company

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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
**SURVIVORSHIP AFFIDAVIT**

STATE OF  
COUNTY **00082679**

{ S. S. 99 OCT -7 AM 9:52

#19900 4909 L0  
On this 9/29/99  
(insert date)

MORRIS W. CARTER  
RECORDER

Therese M. Gazda

Chicago Title Insurance Company

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 daughter of 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  
Joseph A. Mores and Norma Mores;

4. Said Joseph A. Mores  
(fill in name of co-tenant who died)  
died on March 25, 1999

leaving no will;  
(insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:  
lot 18 and the North Half of lot 19 in South Park Subdivision in the City of Hammond, as per plat thereof, Plat Book 11 page 18, Lake Co Indiana

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent:

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?  
No

(If answer is "Yes," identify the divorce proceedings:)

8. Affiant's relationship to the deceased was daughter

Signature: Therese M. Gazda

Address: 2018 Benjamin Pl  
Whiting IN 46394

Subscribed and sworn to before me by the affiant

this 9/29/99  
(insert date)

Shirley R. Kasper  
Notary Public

Shirley R. Kasper  
Notary Public, State of Indiana  
Lake County  
My Commission Exp. 07/31/2000

My Commission Expires \_\_\_\_\_

This instrument prepared by Therese M. Gazda

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12-00  
not  
ct

\* 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

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

Local No. 275

CERTIFICATE OF DEATH

MAR 25 1999 Date Issued  
 Granblin J. Premuda, M.D. Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>JOSEPH A. MORES</b>				2 SEX <b>MALE</b>		3a TIME OF DEATH <b>1:10A M</b>		3b DATE OF DEATH (Month Day Yr) <b>MARCH 25, 1999</b>	
4 *SOCIAL SECURITY NUMBER <b>317-14-9004</b>		5a AGE—Last Birthday (Years) <b>76</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo. Day, Yr) <b>FEB. 2, 1923</b>	
7 BIRTHPLACE (City and State or Foreign Country) <b>HAMMOND, INDIANA</b>		8a WAS DECEDENT A US VETERAN? <b>YES</b>		8b YEAR LAST SERVED IN US ARMED FORCES? <b>1945</b>		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) <b>HAMMOND/WHITING CARE CENTER</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>HAMMOND</b>		9d COUNTY OF DEATH <b>LAKE</b>			
10 MARITAL STATUS (Specify) <b>MARRIED</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>NORMA J. ROWE</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>OPERATOR</b>		12b KIND OF BUSINESS/INDUSTRY <b>AMOCO OIL COMPANY</b>			
13a RESIDENCE—STATE <b>INDIANA</b>		13b COUNTY <b>LAKE</b>		13c CITY, TOWN OR LOCATION <b>HAMMOND (WHITING P.O.)</b>		13d STREET AND NUMBER <b>2439 NEW YORK AVENUE</b>			
13e ZIP CODE <b>46394</b>		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? <b>U.S.A.</b>		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)		16 RACE—American Indian, Black, White, etc (Specify) <b>WHITE</b>	
17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1, 4 or 5 +)				18 FATHER'S NAME (First, Middle, Last) <b>STEPHEN MORES</b>		19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY PESUIT</b>			
20a INFORMANT'S NAME (Type/Print) <b>MRS. NORMA J. MORES</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2439 NEW YORK, WHITING, IN 46394</b>		20c Relationship <b>WIFE</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) <b>MARCH 27, 1999 ST. JOHN CEMETERY</b>				21c LOCATION—City or Town, State <b>HAMMOND, INDIANA</b>			
22a EMBALMER'S NAME <b>MARTIN A. DYBEL</b>		22b EMBALMER'S LICENSE NO <b>FDE01019456</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a SIGNATURE OF FUNERAL DIRECTOR <i>Martin A. Dybel</i>		24b LICENSE NUMBER (of Licensee) <b>FDE01019456</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>BARAN &amp; SON, INC., FDIH83007267 1235-119TH, WHITING, IN 46394</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) a <b>UPPER GI TR BLEEDING</b> DUE TO (OR AS A CONSEQUENCE OF) b DUE TO (OR AS A CONSEQUENCE OF) c DUE TO (OR AS A CONSEQUENCE OF) d		Approximate Interval Between Onset and Death <b>3-4 DA</b>							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>ESOPHAGITIS ANEMIA Dehydration</b>		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>N/A</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>N/A</b>			
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>Granblin J. Premuda</i>		29c MEDICAL LICENSE NO <b>01034865</b>		29d DATE SIGNED (Month Day Year) <b>MARCH 25, 1999</b>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>MAHENDRA A. PATEL, M.D., 835-169TH STREET, HAMMOND, INDIANA 46324</b>									
31 HEALTH OFFICER'S SIGNATURE <i>Granblin J. Premuda M.D.</i>						32 DATE FILED (Month Day Year) <b>MARCH 25, 1999</b>			
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.							

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