

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99084028

99 OCT 12 AM 10:55

MORRIS W. CARTER
RECORDER

FILED

OCT 08 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

PATRICIA F. FIAONI, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Silvio J. Fiaoni, Jr. died (without leaving a will) (~~leaving a will~~) on August 9 1999 at Methodist Hospital Southlake Campus

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 63 in Turkey Creek South, Unit 2, in the Town of Merrillville, as per plat thereof, recorded June 22, 1966 in Plat Book 37, Page 58, in the Office of the Recorder of Lake County, Indiana.

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.

Further affiant sayeth not.

COMMUNITY TITLE COMPANY
FILE NO L18394 W

Patricia F. Fiaoni
Patricia F. Fiaoni

Subscribed and sworn to before me, a Notary Public, this 30th day of September, 1999.

Karen Gatons
Notary Public

11.00 EP
#1083 Comm

This instrument prepared by:
Patrick J. McManama, Attorney at Law
Attorney ID#9534-45

KAREN GATONS
Notary Public, State of Indiana
County of Lake
My Commission Expires 11/04/2006

000632

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

Local No. 1859-99

CERTIFICATE OF DEATH

State No.

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) SILVIO J. FIAONI JR.		2 SEX Male	3a TIME OF DEATH 9:57 P.M.	3b DATE OF DEATH (Month Day Year) August 9, 1999
4 *SOCIAL SECURITY NUMBER 334-24-6064	5a AGE—Last Birthday (Years) 67	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr.) May 24, 1932
7a WAS DECEDENT A U.S. VETERAN? Yes	7b YEAR LAST SERVED IN U.S. ARMED FORCES? 1955	8a PLACE OF DEATH (Check only one See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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) Methodist Hospital Southlake Campus		9b CITY TOWN OR LOCATION OF DEATH Merrillville	9c COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Patricia F. Stahlberg	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) Owner/Operator	12b KIND OF BUSINESS/INDUSTRY Marcino's Pizza & Grinders	
13a RESIDENCE—STATE Indiana	13b COUNTY Lake	13c CITY TOWN OR LOCATION Merrillville	13d STREET AND NUMBER 886 W. 72nd Place	
13e ZIP CODE 46410	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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) 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) Silvio Fiaoni Sr.		
19 MOTHER'S NAME (First Middle Maiden Surname) Florence Nastari		20a INFORMANT'S NAME (Type/Print) Patricia F. Fiaoni		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 886 W. 72nd Place, Merrillville, Indiana 46410		20c Relationship Wife		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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 14, 1999 Calumet Park Cemetery		21c LOCATION—City or Town, State Merrillville, Indiana
22a EMBALMER'S NAME Alexis Thanos		22b EMBALMER'S LICENSE NO. FD08600505	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Alexis Thanos</i>		24b LICENSE NUMBER (of Licensee) FD08600505	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Geisen Funeral Home, Inc. #FH83007762 7905 Broadway, Merrillville, IN 46410	
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. RESPIRATORY FAILURE (Approximate Interval Between Onset and Death: 4 hrs) RECURRENT CVA (7 DAYS) (CVD) STAGE CHRONIC RENAL FAILURE (MANY YRS) AUG 13 1999				
PART II Other significant conditions. Conditions contributing to death but not previously stated in Part I. LAKE COUNTY HEALTH DEPARTMENT				
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>Patricia F. Fiaoni</i>		29c MEDICAL LICENSE NO. 01032692	29d DATE SIGNED (Month Day Year) 8/12/99	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Daksha Vyas, M.D., 3229 Broadway, Suite #151, Gary, Indiana 46409				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Hillman, M.D.</i>				32 DATE FILED (Month Day Year) August 13, 1999
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34a PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34d 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, or pedestrian.		

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