3

R68938

AFFIDAVIT

WALTER CZARNIK, being first duly sworn, states upon his oath as follows:

1. That he is the surviving brother of Joseph Czarnik who died on the 23rd day of September, 1999 in East Chicago, Indiana.

2. That a copy of the Certificate of Death issued by the Indiana State Department of Health in conjunction with the death of Joseph Czarnik is attached hereto and made a part hereof.

3. That the said Joseph Czarnik was never married and was the father of no children.

4. That no estate has been opened or will be opened in conjunction with the death of Joseph Czarnik.

5. That no Indiana Inheritance Tax or Federal Estate Tax is due as a result of the death of Joseph Czarnik.

6. That Affiant makes this Affidavit in conjunction with the following described real estate, which real estate was held by the decedent and the Affiant as joint tenants with right of survivorship and not as tenants in common:

Lot 15, Block 1, Walsh's Second Addition to the City of East Chicago, Lake County, Indiana, as shown in Plat Book 3, page 31, in Lake County, Indiana.

Dated this 12th day of October, 1999.

001127

Walter Czarnik
WALTER CZARNIK

FILED

OCT 18 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

CTIC Has made an accommodation recording of the instrument. We Have made no examination of the instrument or the land affected.

13.00

1

Chicago Title Insurance Company

99085868

99 OCT 19 AM 9:18

MORRIS W. CARTER
RECORDER

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, a Notary Public, personally appeared Walter Czarnik, and acknowledged the execution of the foregoing Affidavit.

Witness my hand and Notarial Seal this 12th day of October, 1999.

Lisa Moreno

Lisa Moreno, Notary Public

My Commission Expires: 11-15-06
County of Residence: Lake

Prepared by: Joseph E. Costanza, Attorney at Law, 720 W. Chicago Ave., Suite 238, East Chicago, IN 46312.

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* **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.

Local No. 259

INDIANA STATE DEPARTMENT OF HEALTH

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

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
Joseph Czarnik	Male	8:23a M	Sep 23 1999

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)
314 20 2229	76			Feb 16 1923	East Chicago In

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)
Yes	1946	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
St Catherine Hospital	East Chicago	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
Single	N/A	Loader	Steel Mill

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	East Chicago	4930 Reading Ave

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 +)
46312	☐ No ☒ Yes	☒ No ☐ Yes	USA	☒ No ☐ Yes	White	12	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Andrew Czarnik	Mary Paluszek

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
Walter Czarnik	4930 Reading E. Chicago In 46312	Brother

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)	Sep 27 1999 Holy Cross Cemetery	Calumet City Il

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James W Gholston	1004194	☐ No ☒ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John B. Lesniak	1005491	Lesniak FH3001601 4918 Magoun E. Chicago In46312

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. Vascular collapse	Unknown
	DUE TO (OR AS A CONSEQUENCE OF)	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. Due to arteriosclerotic heart and vascular disease	
	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) Deputy

☐ 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)
Donna Melyon	N/A	October 1, 1999

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Dr. Timothy Kaykovich	10-1-99

FILED
OCT 18 1999
PETER BENJAMIN
LAKE COUNTY AUDITOR
001128

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
September 23, 1999	

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