

3

R 68938

**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 23<sup>rd</sup> 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**

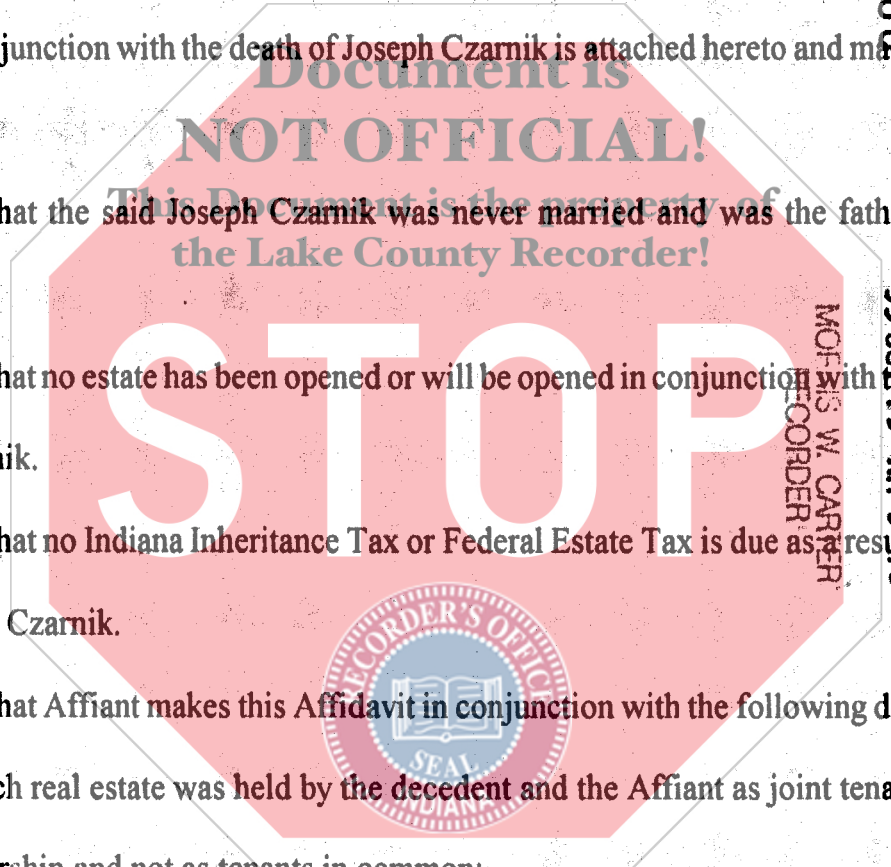
OCT 18 1999

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.

13.000  
OK  
CL

Chicago Title Insurance Company



99085968

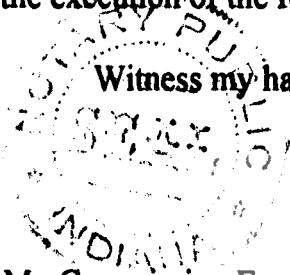
99 OCT 19 AM 9:18

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORDER

MOFIS W. CARRIER  
RECORDER

STATE OF INDIANA     )  
                                  ) SS:  
COUNTY OF LAKE     )

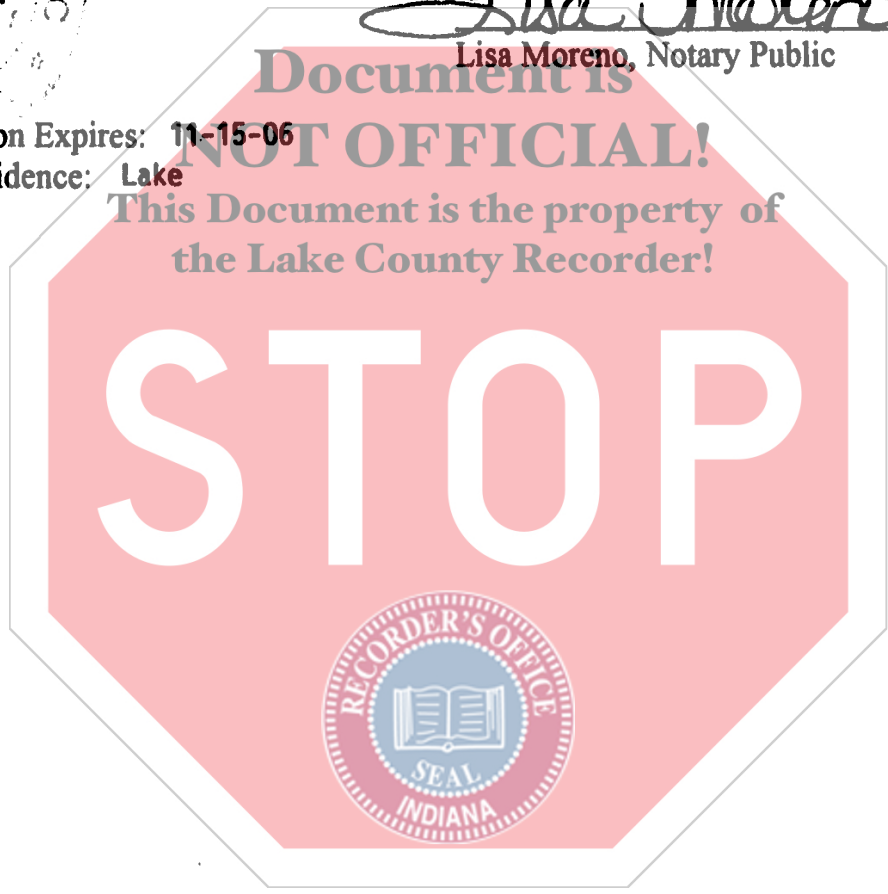
Before me, a Notary Public, personally appeared Walter Czarnik, and acknowledged the execution of the foregoing Affidavit.



Witness my hand and Notarial Seal this 12<sup>th</sup> 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.

\* 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. .... 259 .....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

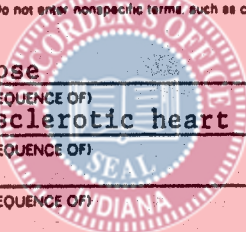
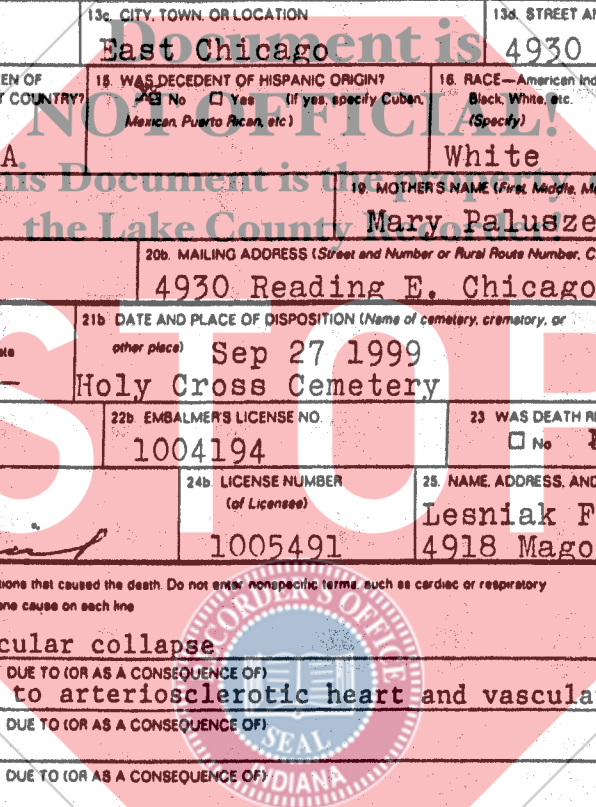
DISPOSITION

CAUSE OF  
DEATH

CERTIFIER

HEALTH  
OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>Joseph Czarnik</b>		2. SEX <b>Male</b>	3a. TIME OF DEATH <b>8:23a M</b>	3b. DATE OF DEATH (Month, Day, Yr) <b>Sep 23 1999</b>
4. SOCIAL SECURITY NUMBER <b>314 20 2229</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 16 1923</b>
7. BIRTHPLACE (City and State or Foreign Country) <b>East Chicago In</b>	8a. WAS DECEDENT A U.S. VETERAN? <b>Yes</b>			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>	8c. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input 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			
9b. FACILITY NAME (If not institution, give street and number) <b>St Catherine Hospital</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>East Chicago</b>		9d. COUNTY OF DEATH <b>Lake</b>
10. MARITAL STATUS (Specify) <b>Single</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Loader</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Steel Mill</b>
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>East Chicago</b>	13d. STREET AND NUMBER <b>4930 Reading Ave</b>	
13e. ZIP CODE <b>46312</b>	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? <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.)	16. RACE—American Indian, Black, White, etc. (Specify) <b>White</b>
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	17. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</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>Andrew Czarnik</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Paluszek</b>		
20a. INFORMANT'S NAME (Type/Print) <b>Walter Czarnik</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4930 Reading E. Chicago In 46312</b>		20c. Relationship <b>Brother</b>
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Sep 27 1999 Holy Cross Cemetery</b>		21c. LOCATION—City or Town, State <b>Calumet City Il</b>
22a. EMBALMER'S NAME <b>James W Gholston</b>		22b. EMBALMER'S LICENSE NO. <b>1004194</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lesniak</i>		24b. LICENSE NUMBER (of Licensee) <b>1005491</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Lesniak FH3001601 4918 Magoun E. Chicago In46312</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.				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>Vascular collapse</b>				<b>Unknown</b>
a. DUE TO (OR AS A CONSEQUENCE OF) <b>Due to arteriosclerotic heart and vascular disease</b>				
b. DUE TO (OR AS A CONSEQUENCE OF)				
c. DUE TO (OR AS A CONSEQUENCE OF)				
d. DUE TO (OR AS A CONSEQUENCE OF)				
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) <b>No</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)
29a. CERTIFIER (Check only one) <input 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 checked="" type="checkbox"/> DEPUTY 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>Walter Czarnik</i>		
29c. MEDICAL LICENSE NO. <b>N/A</b>		29d. DATE SIGNED (Month, Day, Year) <b>October 1, 1999</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Donna Melyon, Deputy Coroner, 2900 West 93rd Avenue, Crown Point, Indiana 46307</b>				
31. HEALTH OFFICER'S SIGNATURE <i>Mr. Timothy Kaykovich</i>				32. DATE FILED (Month, Day, Year) <b>10-1-99</b>
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>OCT 18 1999</b>		
34g. DATE PRONOUNCED DEAD (Month, Day, Year) <b>September 23, 1999</b>		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify date and location. <b>PETER BENJAMIN LAKE COUNTY AUDITOR 001128</b>		



FILED