



Chicago Title Insurance Company

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

99086305

99086305

STATE OF
COUNTY OF

Indiana
Lake

OCT 20 AM 9:46
S. S.
MORRIS W. CARTER
RECORDER

FILED

OCT 19 1999

PETER BENJAMIN
LAKE COUNTY AUDITOR

On this 10-13-99 before me personally appeared _____
(insert date)

#19980544LD

MARY GOLUBIEWSKI

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 Mary Golubiewski;
(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
Mary Golubiewski and Matthew Golubiewski;

4. Said Matthew Golubiewski
(fill in name of co-tenant who died)

died on April 30, 1998

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

5. The legal description of the premises in question is:

Lot 5, Block 8, in Wicker Park, as per plat thereof, recorded in plat Book 20, Page 40, in the Office of the Recorder of Lake County 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 wife

Signature: Mary Golubiewski

Address: 7618 Montana Ave.
Hamid., In 46323

Subscribed and sworn to before me by the affiant

this 10-13-99
(insert date)

Laura J. Brasovan
Laura J. Brasovan Notary Public
Resident of Lake County 8-17-06
My Commission Expires _____

001203

This instrument prepared by MARY GOLUBIEWSKI

11
pr
et

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

20300
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

2

* ATTENTION: ESTATE: The Social Security # is requested by this state agency in order to perform its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 1019-9

1 DECEASED—NAME (First, Middle, Last) MATTHEW EDMUND GOLUBIEWSKI				2 SEX MALE	3a TIME OF DEATH 9:45 A.M.	3b DATE OF DEATH (Month, Day, Yr) APRIL 30, 1998	
4 SOCIAL SECURITY NUMBER 306-01-4548		5a AGE—Last Birthday (Years) 91	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) FEB. 10, 1907	7 BIRTHPLACE (City and State or Foreign Country) CHICAGO, ILLINOIS	
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence					
9b FACILITY NAME (If not institution, give street and number) 8325 BARING AVENUE			9c CITY, TOWN OR LOCATION OF DEATH MUNSTER		9d COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) MARY D. KRAKOWIAK	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) SUPERVISOR		12b KIND OF BUSINESS/INDUSTRY RAILROAD CAR MANUFACTURER			
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION MUNSTER		13d STREET AND NUMBER 8325 BARING AVENUE			
13e ZIP CODE 46321	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 8		
18 FATHER'S NAME (First, Middle, Last) WACLAW GOLUBIEWSKI			19 MOTHER'S NAME (First, Middle, Maiden Surname) HELEN CEBELINSKI				
20a INFORMANT'S NAME (Type/Print) MARY D. GOLUBIEWSKI			20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8325 BARING AVE, MUNSTER, IN 46321		20c Relationship WIFE		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) MAY 5, 1998 ST. JOHN MAUSOLEUM		21c LOCATION—City or Town, State HAMMOND, INDIANA			
22a EMBALMER'S NAME LARRY D. ANTHONY		22b EMBALMER'S LICENSE NO. 01001447		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		24b LICENSE NUMBER (of Licensee) 01001447		24c NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ F.H. #83002916 9445 CALUMET AVE, MUNSTER, IN 46321			
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) INTRACEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF) 1 WEEK							
Conditions, if any, which gave rise to the immediate cause stating the underlying cause last 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) 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>M. F. Kevin</i>				29c MEDICAL LICENSE NO. 01036785		29d DATE SIGNED (Month, Day, Year) MAY 1, 1998	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) M. F. KEVIN, M.D., 7905 CALUMET AVENUE, MUNSTER, INDIANA 46321							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>							
33 MANNER OF DEATH <input 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 DESCRIBE INJURY AND OCCURRENCE OF DEATH OR FILE WITH THE LAKE COUNTY HEALTH DEPT.	
		34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34f LOCATION (Street and Number of Building, City or Town, State) MAY 10, 1998			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <i>Alexander S. Williams MD</i> LAKE COUNTY HEALTH COMMISSIONER					

