

**TICOR TITLE INSURANCE**

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

**AFFIDAVIT**

99 OCT 29 AM 9:09

STATE OF INDIANA ) **99089466**  
                          ) SS:  
COUNTY OF LAKE )

MORRIS W. CARTER  
RECORDER

SOPHIE J. PARKIS, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, GUS T. PARKIS died (without leaving a will) (leaving a will) on MAY 25 1996 at REGENCY NURSING HOME

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 33 IN BLOCK 7 IN ELLENDALE 2ND ADDITION TO THE TOWN OF HIGHLAND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 33 PAGE 92, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

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Key # 27-314-33

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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.



Sophie J. Parkis

Subscribed and sworn to before me, a Notary Public, this 14TH day of OCTOBER, 19 99.

Pamela L. Stanford  
PAMELA L. STANFORD Notary Public

My Commission expires: 08-01-07

County of Residence:

LAKE

**FILED**

This Instrument prepared by SAND RIDGE BANK **OCT 28 1999**

PETER BENJAMIN 001874  
LAKE COUNTY AUDITOR

Return: Sand Ridge BK  
Held.

11/50  
11/11

99207241

TICOR TITLE INSURANCE  
Crown Point, Indiana

\* 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

Local No. 0234-96

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) <b>Gus T. Parkis</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>8:10P<sub>M</sub></b>	3b DATE OF DEATH (Month, Day, Yr) <b>May 25, 1996</b>
4 *SOCIAL SECURITY NUMBER <b>354-03-1456</b>	5a AGE—Last Birthday (Years) <b>75</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) <b>Oct. 1, 1920</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Chicago, IL</b>	8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</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			
9a FACILITY NAME (If not institution, give street and number) <b>Regency Nursing Home</b>		9b CITY, TOWN, OR LOCATION OF DEATH <b>Dyer</b>		9c COUNTY OF DEATH <b>Lake</b>
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Sophie Dremonas</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Maintenance Supervisor</b>		12b KIND OF BUSINESS/INDUSTRY <b>School Town of Highland</b>
13a RESIDENCE—STATE <b>IN</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN, OR LOCATION <b>Highland</b>	13d STREET AND NUMBER <b>3138 Farmer Dr.</b>	
13e ZIP CODE <b>46322</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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 (10-12) <b>10</b> College (1-4 or 5+) <b>---</b>		18 FATHER'S NAME (First, Middle, Last) <b>Thomas Parkis</b>		
19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marina Theropoulos</b>		20a INFORMANT'S NAME (Type/Print) <b>Sophie Parkis</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3138 Farmer Dr. Highland, IN 46322</b>		20c Relationship <b>Wife</b>		
21a METHOD OF DISPOSITION <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>May 29, 1996 Elmwood Cemetery</b>		21c LOCATION—City or Town, State <b>Hammond, IN</b>
22a EMBALMER'S NAME <b>Kevin W. Kish</b>		22b EMBALMER'S LICENSE NO. <b>1021590</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of Licensee) <b>1045184</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Burns-Kish Funeral Home #8800135 921 W. 45th Griffith, IN 46319</b>
26 PART I: Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory. COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. <b>Lung cancer</b>				Approximate Interval Between Onset and Death
IMMEDIATE CAUSE OF DEATH (disease or condition resulting in death) <b>MAY 31 1996</b>				DUE TO (OR AS A CONSEQUENCE OF)
Conditions if any, which give rise to the immediate cause, stating the underlying cause last				DUE TO (OR AS A CONSEQUENCE OF)
PART II: Other significant conditions contributing to death but not previously stated in Part I				DUE TO (OR AS A CONSEQUENCE OF)
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) <b>---</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>[Signature]</i>		
29c MEDICAL LICENSE NO. <b>01030852</b>		29d DATE SIGNED (Month, Day, Year) <b>May 30, 1996</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Elliot Stokar, M.D. 761 45th Munster, IN 46361</b>				
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month, Day, Year) <b>5/31/96</b>
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) <b>OCT 28 1999</b>	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)
34d PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) <b>PETER BENJAMIN LAKE COUNTY AUDITOR</b>		34e DESCRIBE HOW INJURY OCCURRED		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc. <b>001875</b>		