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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 MAR -1 AM 9:52

MONSIEUR W. CARTER
RECORDER

Chicago Title Insurance Company

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

62000039310

On this 25th day of Feb. 2000 before me personally appeared Josephine A. Kappas
(Insert date)

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 owner
(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
John M. Kappas and Josephine A. Kappas;
4. Said John M. Kappas
(fill in name of co-tenant who died)
died on August 10, 1996
leaving no will;
(insert "a" or "no"; if will left, attach a copy)
5. The legal description of the premises in question is:
LOT 21 IN TURKEY CREEK MEADOWS UNIT FOUR PART ONE IN THE TOWN OF MERRILLVILLE
AS PER PLAT THEREOF RECORDED IN PLAT BOOK 38, PAGE 24, IN THE OFFICE OF THE
RECORDER OF LAKE COUNTY, INDIANA

6. Is there Federal Estate or State Inheritance tax liability by reason of the death of said

decendent? Yes No

If yes, then estimated taxes due are \$

The taxes due are paid or unpaid.

FILED

FEB 29 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

01830

13.00
for
CF

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: Josephine A. Kappas

JOSEPHINE A KAPPAS

Printed Name

Document is NOT OFFICIAL
This Document is the property of the Lake County Recorder!

784 W 66th Ave
Address: Merrillville, IN 46410

Subscribed and sworn to before me by the affiant

this 25th day of February 2000
(insert date)

Lori L. Shelby
Notary Public

LORI L. SHELBY
Notary Public, State of Indiana
County of Porter
My Commission Expires Nov. 11, 2007

Printed Name Lori L. Shelby

My County of Residence is: Porter

In the State of Indiana

My Commission Expires 11/11/2007

This Instrument prepared by Josephine A. Kappas

NOTICE: Disclosure of the need to pursue our responsibilities and there will be no penalty for

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

No. 2540-91

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

PRINT IN PERMANENT INK

IDENT

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MANT

SITION

OF

ER

1. DECEASED—NAME (First Middle Last) John M. Kappas		2. SEX Male	3a. TIME OF DEATH 12:50A	3b. DATE OF DEATH (Month, Day, Yr) August 10, 1996
4. SOCIAL SECURITY NUMBER 312-18-7944	5a. AGE—Last Birthday (Year) 74	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) October 3, 1921
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	9. PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence	
10. FACILITY NAME (If not institution, give street and number) Methodist Hospital Southlake		11. CITY, TOWN, OR LOCATION OF DEATH Merrillville	12. COUNTY OF DEATH Lake	
13a. MARITAL STATUS Married	11. SURVIVING SPOUSE (If wife, give maiden name) Josephine Ampeliotis	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Steelworker	12b. KIND OF BUSINESS/INDUSTRY U.S. Steel	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Merrillville	13d. STREET AND NUMBER 784 W 66th Ave	
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 (6-12) <input type="checkbox"/> College (1-4 yr) <input checked="" type="checkbox"/> 12		18. FATHER'S NAME (First Middle Last) Michael Kappas		
19. MOTHER'S NAME (First Middle Maiden Surname) Victoria Gavenda			20. INFORMANT'S NAME (Type/Print) Josephine Kappas	
20a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 784 W. 66th Ave Merrillville, In 46410		20b. Relationship Wife		
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) August 12, 1996 Rigdelawn Cemetery		21c. LOCATION—City or Town, State Gary, Indiana
22a. EMBALMER'S NAME Leonard Gregorczyk		22b. EMBALMER'S LICENSE NO FDO 8800305	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR Robert C. Altiery		24b. LICENSE NUMBER (of Licensee) FDO1001293	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Stilnovich & Wiatrolak FH83004455 7535 Taft St. 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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Aspirin stenosis. Congestive heart failure. DUE TO (OR AS A CONSEQUENCE OF) Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last DUE TO (OR AS A CONSEQUENCE OF) 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 Nuzup Altiery M.D.		29c. MEDICAL LICENSE NO 01028410	29d. DATE SIGNED (Month, Day, Year) 8/15/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print) Dr. Obaid 8995 Broadway Merrillville, Indiana 46410				
31. SIGNATURE OF HEALTH OFFICER William A.D.		32. DATE FILED (Month, Day, Year) 8/19/96		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year) AUG 19 1996	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)		
34f. DATE PRONOUNCED DEAD (Month, Day, Year)		34g. MOTOR VEHICLE ACCIDENT? (Yes or no). If yes, specify driver, passenger, pedestrian, etc. (Specify) LAKELAND HEALTH COMMISSIONER		

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