

2000 MAR -1 AM 11: 58

MICHAEL W. CARTER
RECORDER

2000 014508
AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

Gertrude F. Ancis, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Joseph M. Ancis died ~~(with no will)~~ (leaving a will) on January 23, 2000 at Munster, Indiana

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Unit 1B, 9903 Branton Avenue, in Highland, Indiana, in Eagle Pointe Condominium, Inc., II, a Horizontal Property Regime, established under a Declaration of Condominium recorded December 14, 1995, as Document No. 95076268 and rerecorded December 15, 1995, as Document No. 95076616 and shown in Plat Book 79 page 68, in the Office of the Recorder of Lake County, Indiana, together with an undivided 1/18th interest in the common elements thereto appertaining.

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.

MAR 01 2000
PETER BENJAMIN
LAKE COUNTY RECORDER
SEALED

Gertrude F. Ancis
Gertrude F. Ancis

Subscribed and sworn to before me, a Notary Public, this 29th day of February 2000, ~~19x~~

Maria Elena Orr
Notary Public

"OFFICIAL SEAL"
Maria Elena Orr
Notary Public, State of Illinois
My Commission Exp. 09/25/2003

My Commission expires:

9-25-03

County of Residence:

Cook

This Instrument prepared by W. Lee Newell Jr.

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9903 Branton Ave Unit 1B Highland Am 46322 ←

* 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. 0209-00

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

384307
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) JOSEPH J. ANCIS		2 SEX MALE	3a TIME OF DEATH 7:40 P M	3b DATE OF DEATH (Month Day Yr) JANUARY 23, 2000
4 SOCIAL SECURITY NUMBER 310-22-5381	5a AGE—Last Birthday (Years) 73	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) FEB. 11, 1926
7 BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA		8a PLACE OF DEATH (Check only one See instructions)		
8a WAS DECEASED A US VETERAN? YES	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Other (Specify) HOSPICE RESIDENCE
9a FACILITY NAME (If not institution give street and number) WILLIAM J. RILEY HOSPICE RESIDENCE		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) GERTRUDE DONDAJEWSKI	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) ELECTRICIAN		12b KIND OF BUSINESS/INDUSTRY CAN COMPANY
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION HIGHLAND	13d STREET AND NUMBER 9903 BRANTON AVENUE, 1 B	
13e ZIP CODE 46322	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEASED 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) College (14 or 16) 12		18 FATHER'S NAME (First Middle Last) MICHAEL ANCIS		
19 MOTHER'S NAME (First Middle Maiden Surname) MARY SOPHIA PLOWESKI		20a INFORMANT'S NAME (Type/Print) GERTRUDE ANCIS		
20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 9903 BRANTON AVE., 1B, HIGHLAND, IN. 46322		20c Relationship WIFE		
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) JANUARY 26, 2000 HOLY CROSS CEMETERY		21c LOCATION—City or Town State CALUMET CITY, ILLINOIS
22a EMBALMER'S NAME KEITH D. ANTHONY		22b EMBALMER'S LICENSE NO. 01011911	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24 SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24a LICENSE NUMBER (of Licensee) 01011911	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327	
26 PART I Enter the diseases injuries or complications that caused the death Do not enter non-specific terms such as cardiac or respiratory arrest shock or heart failure List only one cause on each line				Approximate Interval Between Onset and Death 3 weeks
IMMEDIATE CAUSE (Final disease or condition resulting in death) Chronic obstructive lung disease				
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 DECEASED 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 causes 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 causes 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 causes and manner as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>M.D.</i>	29c MEDICAL LICENSE NO. 01044314	29d DATE SIGNED (Month Day Year) JANUARY 25, 2000
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) NOUR KABBANI M.D. 110 RIDGE ROAD, MUNSTER, INDIANA 46321				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams MD</i>				32 DATE FILED (Month Day Year) January 25, 2000
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		33a DATE OF INJURY (Month Day Year)	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)
33d PLACE OF INJURY—At home farm street factory office building etc (Specify)		33e DESCRIBE HOW INJURY OCCURRED		
34a DATE PRONOUNCED DEAD (Month Day Year)		34b MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc		