

STATE OF INDIANA
LAKE COUNTY
FILED IN RECORD

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STATE OF INDIANA)
) SS:
COUNTY OF PORTER)

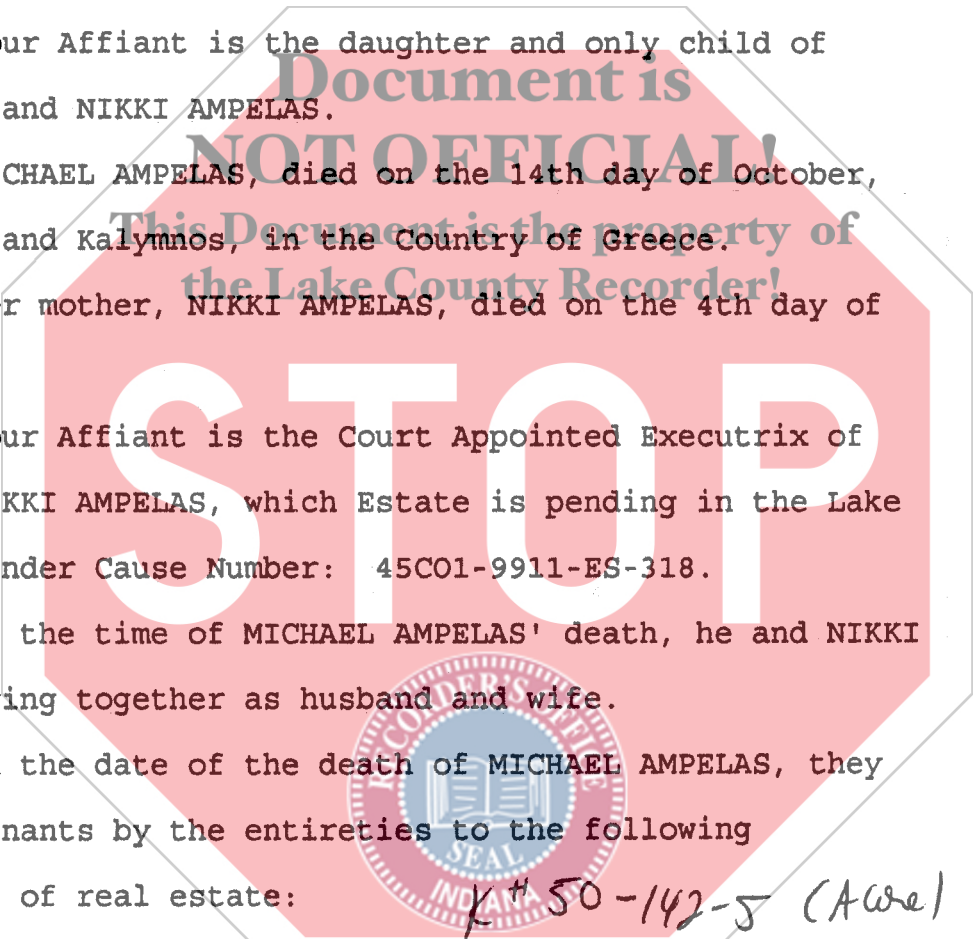
AFFIDAVIT

PETER BENJAMIN
LAKE COUNTY AUDITOR

Comes now KALLY TSANGARIS, who being first duly sworn upon her oath, deposes and says as follows:

1. That your Affiant is the daughter and only child of MICHAEL AMPELAS and NIKKI AMPELAS.
 2. That MICHAEL AMPELAS, died on the 14th day of October, 1967, on the island Kalymnos, in the Country of Greece.
 3. That her mother, NIKKI AMPELAS, died on the 4th day of July, 1999.
 4. That your Affiant is the Court Appointed Executrix of the Estate of NIKKI AMPELAS, which Estate is pending in the Lake Circuit Court, under Cause Number: 45CO1-9911-ES-318.
 5. That at the time of MICHAEL AMPELAS' death, he and NIKKI AMPELAS were living together as husband and wife.
 6. That on the date of the death of MICHAEL AMPELAS, they held title as tenants by the entireties to the following described parcel of real estate:
K # 50-142-5 (Awe)
- North half of Lot 5, Block 2, Liverpool Home Gardens, as per plat thereof, recorded in Plat Book 23, Page 45, in the Office of the Recorder of Lake County, Indiana, more commonly known as 2770 Oklahoma Street, Lake Station, Indiana, 46405.
7. That all funeral expenses have been paid and also that

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TICOR TITLE INSURANCE
2686 Willowcreek Road
Portage, IN 46368

1400
EP.
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25X

the estate of the deceased did not exceed \$600,000.00.

Further, your Affiant further sayeth not.

Kally Tsangaris
KALLY TSANGARIS

Subscribed and sworn to before me this 3rd day of
March, 2000.

Betty Jean Gesin
Betty Jean Gesin,
Notary Public

Resident of Lake County

My Commission Expires: March 6, 2008

NOT OFFICIAL!

This Document is the property of
the Lake County Recorder!

prepared by:
Kally Tsangaris

STOP



7009

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. 1559-99

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) NIKKI AMPELAS		2 SEX FEMALE		3a TIME OF DEATH		3b DATE OF DEATH (Month Day Yr) JULY 4, 1999	
4 SOCIAL SECURITY NUMBER 313-07-1074		5a AGE—Last Birthday (Years) 92		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo. Day, Yr) AUG. 8, 1907		7 BIRTHPLACE (City and State or Foreign Country) GREECE					
8a WAS DECEDENT A US VETERAN? NO		8b YEAR LAST SERVED IN US ARMED FORCES?		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 checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) ST. ANTHONY CONVALESCENT CENTER			9c CITY, TOWN, OR LOCATION OF DEATH CROWN POINT			9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) WIDOWED		11 SURVIVING SPOUSE (If wife, give maiden name) NONE		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) HOMEMAKER		12b KIND OF BUSINESS/INDUSTRY AT HOME	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION LAKE STATION		13d STREET AND NUMBER 2770 OKLAHOMA STREET	
13e ZIP CODE 46405		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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)					
18 FATHER'S NAME (First Middle Last) THEOLOGOS SAMARKOS				19 MOTHER'S NAME (First Middle Maiden Surname) KALLIOPY KAPSIS			
20a INFORMANT'S NAME (Type/Print) KALLY TSANGARIS				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9420 HAYES STREET, CROWN POINT, IN. 46307		20c Relationship DAUGHTER	
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) JULY 7, 1999 CALUMET PARK CEMETERY		21c LOCATION—City or Town, State MERRILLVILLE, INDIANA			
22a EMBALMERS NAME GORDON L. JONES		22b EMBALMER'S LICENSE NO 01010711		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>James E. Burns</i>		24b LICENSE NUMBER (of Licensee) 01009461		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME FDH#83002445 10101 S. BROADWAY, CROWN POINT, IN. 46307			
26 PART I Enter the disease, 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) a Congestive Heart Failure b JUL 6 1999 c FILED d Conditions if any which gave rise to the immediate cause stating the underlying cause last		27 WAS DECEDENT POSTMORTEM? (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)	
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I							
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>Peter Benjamin</i> PETER BENJAMIN LAKE COUNTY AUDITOR					
29c MEDICAL LICENSE NO 01037515		29d DATE SIGNED (Month Day Year) 7-6-99					
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MILTON GASPARIS, M. D., 1400 S. LAKE PARK, HOBART, INDIANA 46342							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, M.D.</i>						32 DATE FILED (Month Day Year) July 6, 1999	
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)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
34d DESCRIBE HOW INJURY OCCURRED		34e PLACE OF INJURY—At home farm street factory office building etc (Specify)			34f LOCATION (Street and Number or Rural Route Number, City or Town, State)		
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc					

