

FA # F30910

LEGAL DESCRIPTION:

Lot(s) 21, of Dixons 2nd Add, Map Book S34, Map Page 24  
2000 017457

STATE OF INDIANA  
LAKE COUNTY  
FILED  
2000 MAR 13 11:03:21  
MUNICIPAL CLERK



PROPERTY ADDRESS:  
1104 North Dwiglins  
Griffith, IN 46319

ESTATE AFFIDAVIT

GLORIA FILIPS, Affiant, states that:

1. JOHN FILIPS, deceased, died on the 12TH day of JUNE, 1999.

2. Affiant is:  the surviving spouse of the deceased,  
 the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died:  leaving a will which has been probated;  
 leaving a will which has not been probated;  
 leaving no will;

4. The deceased and Affiant were married on the 15th day of JUNE, 1946; and were never divorced.  
(This item applies only to the surviving spouse.)

5.  All expenses of the last illness and funeral of the deceased have been paid;

6.  All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7.  There are no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

MARCH 8 2000

Date

Gloria Filips  
Signature of Affiant

GLORIA FILIPS

Printed Name of Affiant

State of Indiana, County of LAKE

Subscribed and sworn to before me, this 8TH day of MARCH, 2000.

ANDREA A WIDLOWSKI

Andrea A Widlowski  
Printed Name of Notary

Andrea A Widlowski  
Signature of Notary

My Commission expires: 9-17-2001

My County of Residence is: LAKE

THIS INSTRUMENT WAS PREPARED BY: GLORIA FILIPS

PETER BENJAMIN  
LAKE COUNTY AUDITOR

FILED

MAR 13 2000

HOLD FOR FIRST AMERICAN TITLE

00916

① F30910

11.00  
E.P.  
FA

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\* 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. .... 1435-99

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

#269301 TYPE/PRINT IN PERMANENT BLACK INK

1 DECEASED—NAME (First Middle Last) <b>MACK John</b>		2 SEX <b>FILIPS MALE</b>		3a TIME OF DEATH <b>8:08 A.M.</b>	3b DATE OF DEATH (Month Day Yr) <b>JUNE 12, 1999</b>
4 *SOCIAL SECURITY NUMBER <b>314-18-9906</b>		5a AGE—Last Birthday (Years) <b>77</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr) <b>Dec. 27, 1921</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>		8a WAS DECEDENT A U.S. VETERAN? <b>Yes</b>			
8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1945</b>		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>			9c CITY TOWN OR LOCATION OF DEATH <b>MUNSTER</b>		9d COUNTY OF DEATH <b>LAKE</b>
10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Gloria Huta</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use "retired") <b>Retired transportation</b>	
12b KIND OF BUSINESS/INDUSTRY <b>L.T.V. Steel Co.</b>					
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY TOWN OR LOCATION <b>Griffith</b>	
13d STREET AND NUMBER <b>1104 N. Dwiggins</b>					
13e ZIP CODE <b>46319</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		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 (0-12) <b>12</b> College (1-4 or 5+)					
18 FATHER'S NAME (First Middle Last) <b>Thomas Filipowicz</b>			19 MOTHER'S NAME (First Middle Maiden Surname) <b>Veronica Winter</b>		
20a INFORMANT'S NAME (Type/Print) <b>Gloria Filipis</b>		20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) <b>1104 N. Dwiggins, Griffith, In 46319</b>		20c Relationship <b>Wife</b>	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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>June 16, 1999 Calvary Cemetery</b>		21c LOCATION—City or Town State <b>Portage, Indiana</b>	
22a EMBALMER'S NAME <b>Anthony S. Rendina Jr.</b>		22b EMBALMER'S LICENSE NO (of License) <b>FD01010402</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Anthony S. Rendina Jr.</i>		24b LICENSE NUMBER (of License) <b>FD01010402</b>		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Rendina Funeral Home FH83007819 5100 Cleveland St. Gary, In 4640</b>	
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) a. <b>METABOLIC ACIDOSIS</b> 4 Hours DUE TO (OR AS A CONSEQUENCE OF) b. <b>CARDIOGENIC SHOCK</b> 4 Hours DUE TO (OR AS A CONSEQUENCE OF) c. <b>CARDIAC ARITHMIA</b> 10 minutes DUE TO (OR AS A CONSEQUENCE OF) d. <b>ESOPHAGEAL CARCINOMA</b> 1 month. PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>CORONARY ARTERY DISEASE CEREBRAL ATROPHY</b>					
27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/>					
28a WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/>					
28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input type="checkbox"/>					
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>John Williams</i>			29c MEDICAL LICENSE NO <b>01050109</b>		29d DATE SIGNED (Month Day Year) <b>JUNE 17, 1999</b>
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>TEOMAN DEMIR, M.D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321</b>					
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams, MD</i>					32 DATE FILED (Month Day Year) <b>6/18/99</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)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED <b>JUN 18 1999</b>
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 <b>03327</b>			

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