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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 019789



TICOR TITLE INSURANCE

2000 MAR 22
MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

ANNE KUMIEGA, being first duly
sworn upon oath, deposes and says:

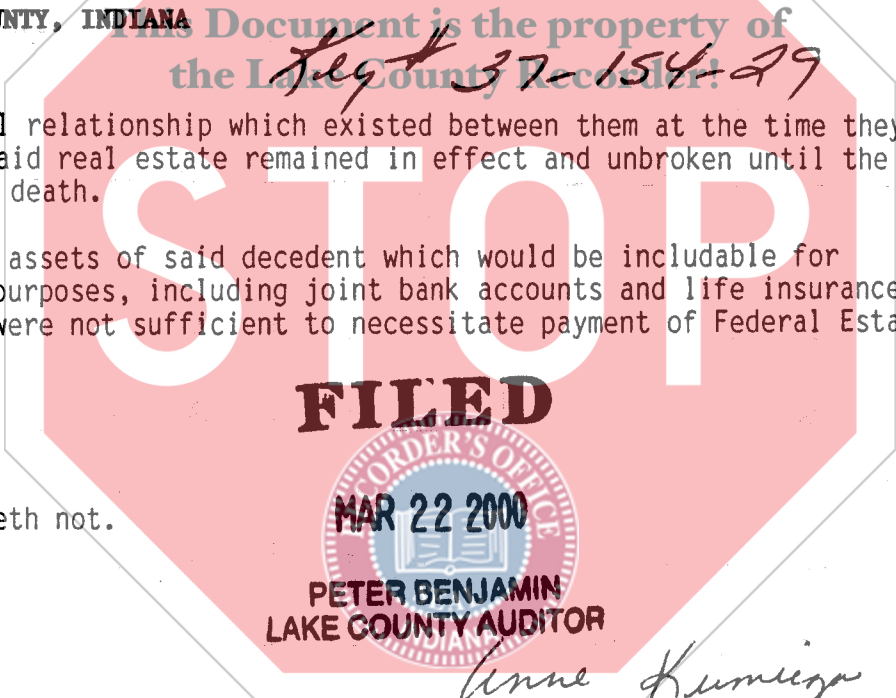
1. That THEODORE J. KUMIEGA died on
MARCH 27, 1992 at LAKE COUNTY.

2. That THEODORE J. KUMIEGA and ANNE KUMIEGA
were duly and legally married at the time they acquired title as husband and
wife to the following described real estate: THE SOUTH 50 FEET OF THE FOLLOWING
DESCRIBED TRACT. THE EAST 1/2 OF THE EAST 1/2 OF THE NORTHWEST 1/4 OF THE SOUTH
WEST 1/4 OF SECTION 9 TOWNSHIP 36 NORTH, RANGE 9 WEST OF THE 2ND PRINCIPAL MERIDIAN
IN THE CITY OF HAMMOND, LAKE COUNTY INDIANA, EXCEPTING THEREFROM THE SOUTH 810 FEET
THEREOF AND EXCEPTING THOSE PARTS CONVEYED TO THE INDIANA HARBOR RAILROAD COMPANY
AND ANNE L. ILLIFF BY DEEDS RECORDED IN DEED RECORD 101 PAGE 137, DEED RECORD 104
PAGE 396 AND DEED RECORD 268 PAGE 203 RESPECTIVELY, IN THE OFFICE OF THE
RECORDER OF LAKE COUNTY, INDIANA

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 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.



Anne Kumiega
ANNE KUMIEGA

Subscribed and sworn to before me, a Notary Public, this 17TH day of
MARCH, 19 2000.

Susan M. Downing
SUSAN M. DOWNING
Notary Public
Exp. _____
LAKE COUNTY, INDIANA

My Commission expires:

4-10-07

County of Residence:

LAKE

This Instrument prepared by ANNE KUMIEGA

01509

11.00
E.P.
11

**INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH**

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Local No. 249

Date Issued Apr. 2, 1992 *Franklin D. Remuda M.D.*
Hammond Health Commissioner

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CRONER
SE ONLY

1 DECEASED—NAME (First, Middle, Last) Theodore J. Kumiega		2 SEX Male		3a TIME OF DEATH 9:28 A M		3b DATE OF DEATH (Month, Day, Yr.) March 27, 1992	
4 SOCIAL SECURITY NUMBER 315-10-3692		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.) Nov 28, 1918		7 BIRTHPLACE (City and State or Foreign Country) East Chicago, Indiana					
8a WAS DECEDENT A US VETERAN? Yes		8b YEAR LAST SERVED IN US ARMED FORCES? 1945		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 type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b FACILITY NAME (If not institution, give street and number) 6937 Lindbergh Avenue				9c CITY, TOWN, OR LOCATION OF DEATH Hammond		9d COUNTY OF DEATH Lake	
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Anne Muse		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Welder		12b KIND OF BUSINESS/INDUSTRY Youngstown Sheet & Tube	
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN OR LOCATION Hammond		13d STREET AND NUMBER 6937 Lindbergh Avenue	
13e ZIP CODE 46323		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) 12 College (1-4 or 5+) 12					
18 FATHER'S NAME (First, Middle, Last) Walter Kumiega				19 MOTHER'S NAME (First, Middle, Maiden Surname) Ann Martha Mikula			
20a INFORMANT'S NAME (Type/Print) Mrs. Anne Kumiega		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6937 Lindbergh Ave., Hammond, IN 46323			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) March 31, 1992 St. John Cemetery		21c LOCATION—City or Town, State Hammond, Indiana			
22a EMBALMER'S NAME Charles D. Scheuer, Jr.		22b EMBALMER'S LICENSE NO. 1006049		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>Charles D. Scheuer, Jr.</i>		24b LICENSE NUMBER (of Licensee) 1006049		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Virgil Huber Funeral Home 3002869 7051 Kennedy Ave., Hammond, IN 46323			
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 Vascular collapse b Due to arteriosclerotic heart and vascular disease c Due to arteriosclerotic heart and vascular disease d							Approximate Interval Between Onset and Death Unknown
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) N/A	
29a CERTIFIER (Check only one) <input 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 checked="" 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>Franklin D. Remuda</i>					29c MEDICAL LICENSE NO. 16120		29d DATE SIGNED (Month, Day, Year) April 2, 1992
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Daniel D. Thomas, M.D., Coroner, 2293 North Main Street, Crown Point, Indiana 46307							
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remuda M.D.</i>						32 DATE FILED (Month, Day, Year) APRIL 2, 1992	
33 MANNER OF DEATH <input checked="" 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	
		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) March 27, 1992		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

25x10