STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 020662 2000 MAR 27 AM 8:58

MORRIS W. CARTER
RECORDER

TICOR TITLE INSURANCE

FILED

MAR 24 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Mabel Lee Malinich, being first duly sworn upon oath, deposes and says:

1. That John Malinich died on September 7, 1994 at Hobart, Indiana.

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

Lot 9 in Lohman's Addition to Ranburn Woods, as per plat thereof, recorded in Plat Book 28 page 19, in the Office of the Recorder of Lake County, Indiana.

Key No. 39-471-9.

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.

Mabel Lee Malinich
Mabel Lee Malinich

Subscribed and sworn to before me, a Notary Public, this 23rd day of March, 2000 A.D.

Shannon Stiener
Shannon Stiener Notary Public

My Commission expires:

3-14-07

County of Residence:

Lake

This Instrument prepared by Mabel Lee Malinich

#1952

Ticor-C.P. 920000789 Wilcox

TION ESTATE: Disclosure of the
ieed to pursue our responsibilities
ry and there will be no penalty for

No. 2136-94

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

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

1 DECEASED—NAME (First, Middle, Last): John Malinich			2 SEX: Male	3a TIME OF DEATH: 10:20 AM	3b DATE OF DEATH (Month, Day, Yr): September 7, 1994
4 SOCIAL SECURITY NUMBER: 313-07-3818	5a AGE—Last Birthday (Years): 76	5b UNDER 1 YEAR: Months / Days	5c UNDER 1 DAY: Hours / Minutes	6 DATE OF BIRTH (Mo, Day, Yr): Sep. 10, 1917	7 BIRTHPLACE (City and State or Foreign Country): Mc Kees Rock, Pa.
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9a PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA	OTHER ☒ Nursing Home ☐ Other (Specify) ☐ Residence		
9b FACILITY NAME (If not institution, give street and number): Sebo Nursing Home		9c CITY, TOWN OR LOCATION OF DEATH: Hobart		9d COUNTY OF DEATH: Lake	
10 MARITAL STATUS (Specify): Married	11 SURVIVING SPOUSE (If wife, give maiden name): Mabel Davis	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Maintenance		12b KIND OF BUSINESS/INDUSTRY: Steel Co.	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Gary		13d STREET AND NUMBER: 2801 W. 41st Ave.	
13e ZIP CODE: 46408	13f INSIDE CITY LIMITS? ☒ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY: U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ 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): 10; College (1-4 or 5+):
	13g ON A FARM? ☒ No ☐ Yes				
18 FATHER'S NAME (First, Middle, Last): Peter Malinich		19 MOTHER'S NAME (First, Middle, Maiden Surname): Julia Stercho			
20a INFORMANT'S NAME (Type/Print): Mabel malinich		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2801 W. 41st Ave. Gary, Indiana		20c Relationship: Wife	
21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 10, 1994 Calumet Park Cemetery		21c LOCATION—City or Town, State: Merrillville, Indiana	
22a EMBALMER'S NAME: Edgar Gleim		22b EMBALMER'S LICENSE NO: FDO 1016713	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes		
24a SIGNATURE OF FUNERAL DIRECTOR: [signature]		24b LICENSE NUMBER (of Licensee): FDO 1014511	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500		

THIS CERTIFICATE ABOVE COMPLETED ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

SEP 06 1994

LAKE COUNTY HEALTH DEPARTMENT

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. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Upper G.I. hemorrhage - poss. by perforated ulcer

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last:
DUE TO (OR AS A CONSEQUENCE OF): b.
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not previously stated in Part I

	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
P/S Fx'd (R) hip Hx'd seizure disorder Syncope Type diabetes mellitus Coronary art. disease	NO	NO	

29a. CERTIFIER (Check only one)
☒ CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date, and place, and due to the cause(s) as stated
☐ 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
☐ 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	29c. MEDICAL LICENSE NO	29d. DATE SIGNED (Month, Day, Year)
Robert A. Wilcox M.D.	IN # 20894	Sept. 8, 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Spectrum 1354 S. Lake Park Hobart IN 46342

31. HEALTH OFFICER'S SIGNATURE: Alexander D. Williams M.D.

32. DATE SIGNED (Month, Day, Year): September 8, 1994

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide				
	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.			

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1

25 x