2.

STATE OF INDIANA
LAKE COUNTY
FILED
2000 MAR 21 AM 10:

2000 022106

AFFIDAVIT

State of Indiana)
) SS:
County of Porter)

ELEANOR WUSIK, TRUSTEE, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, MICHAEL WUSIK died (without leaving a will) (leaving a will) on 1-8-97 at Community Hospital

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

LOT 20 IN BLOCK 5 IN GREEN LAWN ADDITION TO HAMMOND, AS PER PLAT THEREOF, RECORDED DECEMBER 31, 1924 IN PLAT BOOK 17 PAGE 28, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS: 7229 MCCOOK, HAMMOND, IN 46323

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.

FILED

MAR 23 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

Eleanor Wusik Trustee
ELEANOR WUSIK

Subscribed and sworn to before me, a Notary Public, this 17th day of March 2000.

COMMUNITY TITLE COMPANY
FILE NO L 19182 mj

Tracie A. Kraszyk

PREPARED BY PATRICK J. MCMANAMA
ATTORNEY I.D. NO. 9534-45

01805

TRACIE A. KRASZYK
Notary Public, State of Indiana
County of Porter
My Commission Expires Jan. 12, 2008

Comm #1264
1-1
am

* **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

Local No. 0066-97 43631

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last)		2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
MICHAEL	WUSIK	MALE	11:35 P.M.	JANUARY 8, 1997

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
311-03-6883	81			September 19,1915	Hammond, Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1946	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
THE COMMUNITY HOSPITAL	MUNSTER	LAKE

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Married	Eleanor Bartkowski	Gas Station Operator	Self Employed

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hammond	7229 McCook Avenue

13e. ZIP CODE	13f. INSIDE CITY LIMITS	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
					Elementary/Secondary (0-12)	College (1-4 or 5+)
46323	13g. ON A FARM? ☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12th	

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Steven Wusik	Antionette Medvid

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Eleanor Wusik	7229 McCook Ave.,Hammond,Indiana 46323	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	January 11, 1997 St. John Cemetery	Hammond, Indiana

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
Dean G. Wagner	8800057	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John A. Quigini	1007231	Solan Funeral Home FH83002893 7109 Calumet Ave.,Hammond,In. 46324

CAUSE OF DEATH

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. MULTI-ORGAN SYSTEM FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF) b. CONGESTIVE HEART FAILURE	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF) JAN 10 1997	
	DUE TO (OR AS A CONSEQUENCE OF)	

PART II Other significant conditions contributing to death but not previously stated in Part I: DIABETES MELLITUS II; CEREBROVASCULAR ACCIDENT; DEMENTIA

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)
	NO	

CERTIFIER

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)
Mark Kevin MD	36785	1/9/97

HEALTH OFFICER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARK KEVIN, M.D. 7905 CALUMET AVENUE MUNSTER, INDIANA 46321

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
	January 10,1997

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 ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be Determined				

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.