STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 027567

2000 APR 24 ... 07

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

VIOLET BARTLETT, being first duly sworn upon oath, deposes and says:

1. That HELEN NOWICKI died on NOVEMBER 19, 1990 at LAKE COUNTY, INDIANA.

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

LOTS 13 AND THE EAST 25 FEET OF LOT 12 IN BLOCK 2 IN SOUTHMOOR ADDITION TO THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 20 PAGE 27, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

KH 26-94-12

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.

FILED
APR 24 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

Further affiant sayeth not.

x Violet Bartlett
VIOLET BARTLETT

Subscribed and sworn to before me, a Notary Public, this 10 day of APRIL, 2000

Sandra I. Hartwig
Notary Public

My Commission expires:
11-1-2000

NOTARY PUBLIC - STATE OF FLORIDA
SANDRA I. HARTWIG
COMMISSION # CC586684
EXPIRES 11-1-2000
BONDED THRU ASA 1-888-NOTARY-1

County of Residence:
CHARLOTTE

This Instrument prepared by VIOLET BARTLETT

Ticor No 920004425

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

April 13, 2000 — Date Issued — Hammond Health Commissioner

Local No. 986

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last): HELEN NOWICKI
2 SEX: FEMALE
3a TIME OF DEATH: 9:57 AM
3b DATE OF DEATH (Month, Day, Yr): NOVEMBER 19, 1990
4 SOCIAL SECURITY NUMBER: 311-32-9061
5a AGE—Last Birthday (Years): 63
5b UNDER 1 YEAR (Months, Days):
5c UNDER 1 DAY (Hours, Minutes):
6 DATE OF BIRTH (Mo, Day, Yr): AUG. 4, 1927
7 BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a WAS DECEDENT A U.S. VETERAN?: NO
8b YEAR LAST SERVED IN US ARMED FORCES?: —
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): 231 - 174TH STREET
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): EDWARD NOWICKI
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: OWN HOME
13a RESIDENCE—STATE: INDIANA
13b COUNTY: LAKE
13c CITY, TOWN, OR LOCATION: HAMMOND
13d STREET AND NUMBER: 231 - 174TH STREET
13e ZIP CODE: 46324
13f INSIDE CITY LIMITS: ☐ No ☒ Yes
13g ON A FARM?: ☒ No ☐ Yes
14 CITIZEN OF WHAT COUNTRY?: USA
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): 12; College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last): JOSEPH HERDZIK
19 MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE UNAVAILABLE

INFORMANT

20a INFORMANT'S NAME (Type/Print): EDWARD NOWICKI
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 231 - 174TH ST, HAMMOND, INDIANA 46327
20c Relationship: HUSBAND

DISPOSITION

21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Donation ☐ Other (Specify) ☐ Entombment ☐ Removal from State
21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): NOVEMBER 21, 1990 HOLY CROSS CEMETERY
21c LOCATION—City or Town, State: CALUMET CITY, ILLINOIS
22a EMBALMER'S NAME: KEITH D. ANTHONY
22b EMBALMER'S LICENSE NO: 01011911
23 WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b LICENSE NUMBER (of Licensee): 01011911
25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835, 4404 CAMERON, HAMMOND, IN 46327

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

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Vascular collapse — Approximate Interval Between Onset and Death: Unknown
DUE TO (OR AS A CONSEQUENCE OF)
b. Due to arteriosclerotic heart and vascular disease.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

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): 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: Daniel D Thomas
29c MEDICAL LICENSE NO.: 16120
29d DATE SIGNED (Month, Day, Year): November 27, 1990
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DANIEL D. THOMAS M.D. 2293 N. MAIN STREET, CROWN POINT, INDIANA 46307

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Franklin I. [illegible] M.D.
32 DATE FILED (Month, Day, Year): NOV 28 1990

CORONER USE ONLY

33 MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
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): November 19, 1990
34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc:

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PO 1

Ticor No 92000 142 Buchanan