DULY ENTERED FOR TAXATION SUBJECT TO

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 028990

2000 MAY -

TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Kathryn Lukich, being first duly sworn upon oath, deposes and says:

1. That Michael Lukich died on August 16, 1996 at Community Hospital.

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

Lot 115, Novo-Selo Unit No. 3, in the Town of Schererville, as per plat thereof, recorded in Plat Book 38 page 67, in the Office of the Recorder of Lake County, Indiana.

FILED
APR 28 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

K# 13-282-11

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.

Kathryn Lukich
Kathryn Lukich

Subscribed and sworn to before me, a Notary Public, this 25th day of April, 2000.

Denise K. Zawada
Notary Public
Denise K. Zawada

My Commission expires:
8/31/2006

County of Residence:
Lake

DENISE K. ZAWADA NOTARY Exp. 8/31/06 PUBLIC, INDIANA LAKE COUNTY

41652

This Instrument prepared by Kathryn Lukich

11.00 EP. T1

A2000 1477 Ticor sch Res

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.

Local No. 2609-96

11522

TYPE/PRINT IN PERMANENT BLACK INK

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

DECEDENT

1 DECEASED—NAME (First, Middle, Last)		2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
MICHAEL	LUKICH	MALE	5:20 AM	AUGUST 16, 1996

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)
314-05-0422	77			NOVEMBER 27, 1918	EAST CHICAGO, INDIANA

8a WAS DECEDENT A US VETERAN?	8b YEAR LAST SERVED IN US ARMED FORCES*	9a PLACE OF DEATH (Check only one. See instructions)
YES	1945	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
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	KATHRYN SPUDIC	RETIRED TRUCK OPERATOR	U.S GYPSUM

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	SCHERERVILLE	811 APPLE TREE DR.

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	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)	
46375	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A	☒ No ☐ Yes	WHITE	Elementary/Secondary (0-12): 12	College (1-4 or 5+):

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
GEORGE LUKICH	SOPHIA MESZAR

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
KATHRYN LUKICH	811 APPLE TREE DR. SCHERERVILLE, IN. 46375	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 ☐ Removal from State ☐ Donation ☐ Other (Specify)	AUGUST 19, 1996 ST. MICHAEL CEM.	SCHERERVILLE, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
CHARLES WELLS	FD01142372	☐ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
	FD01008300	LINCOLN RIDGE FUNERAL HOME 88800070 7607W. LINCOLN HWY. CROWN POINT, IND. 46

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

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)	28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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)
	33507	AUGUST 21 1996

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)

HOWARD M. MISHOURAM, M.D. 1630 45TH AVENUE MUNSTER, INDIANA

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: Alexander D. Gilliam, M.D.

THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

32 DATE FILED (Month, Day, Year): 8/21/96

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				AUG 21 1996

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)
	Alexander D. Gilliam, MD

34g DATE PRONOUNCED DEAD (Month, Day, Year)	34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.
	LAKE COUNTY HEALTH COMMISSIONER

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