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FA# F31797

LEGAL DESCRIPTION: 2000-034632

The North 25 feet of Lot 19 and the South 10 feet of Lot 20, in Block 11, in Park View Addition to Hammond, as per plat thereof recorded in Plat Book 181 page 19, 5 in the Office of the Recorder of Lake County, Indiana.

STATE FILED

MONITORING RECORDER



First American Title Insurance Company

PROPERTY ADDRESS:
1645 Parkview Avenue, Whiting, IN 46394

ESTATE AFFIDAVIT

Janet Marie Dunning

, Affiant, states that:

1. Edward F. Kowal, Sr.
of OCT, 1999

, deceased, died on the 28th day

2. Affiant is: the surviving spouse of the deceased,
 the Personal Representative/Executor-trix of the estate of the deceased;

DAUGHTER

3. The deceased died: leaving a will which has been probated;
 leaving a will which has not been probated;
 leaving no will;

4. The deceased and Affiant were married on the _____ day _____ of _____; and were never divorced.
(This item applies only to the surviving spouse.)

5. All expenses of the last illness and funeral of the deceased have been paid;
6. All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;
7. There have been no claims against the estate of the decedent.

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

Date MAY 15 2000

Signature of Affiant Janet Marie Dunning

Printed Name of Affiant Janet Marie Dunning

State of Indiana, County of _____

Signature of Notary Edward Grabovac

Subscribed and sworn to before me, this 15th day of May 2000

Beth A. Kolbert
Printed Name of Notary

Signature of Notary Beth A. Kolbert

My Commission expires: 07/11/01

My County of Residence is: Lake

THIS INSTRUMENT WAS PREPARED BY: EDWARD GRABOVAC

HOLD FOR FIRST AMERICAN TITLE

02170

12.00 EP FA

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.
Date Issued: Nov. 1, 1999
Hammond Health Commissioner

Local No. 859

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) EDWARD F. KOWAL, SR.				2 SEX MALE	3a TIME OF DEATH 5:50P	3b DATE OF DEATH (Month Day Year) OCTOBER 28, 1999
4 SOCIAL SECURITY NUMBER 313-01-5650	5a AGE—Last Birthday (Year) 89	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Year) AUG. 9, 1910	7 BIRTHPLACE (City and State or Foreign Country) WHITING, INDIANA	
8a WAS DECEDENT A US VETERAN? NO	8b YEAR LAST SERVED IN US ARMED FORCES? N/A	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 checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence				
9b FACILITY NAME (If not institution give street and number) 1645 PARKVIEW AVENUE			9c CITY TOWN OR LOCATION OF DEATH HAMMOND		9d COUNTY OF DEATH LAKE	
10 MARITAL STATUS (Specify) WIDOWED	11 SURVIVING SPOUSE (If wife give maiden name) NONE	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) MACHINIST			12b KIND OF BUSINESS/INDUSTRY AMOCO OIL COMPAN	
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY TOWN OR LOCATION HAMMOND (WHITING P.O.)		13d STREET AND NUMBER 1645 PARKVIEW AVENUE		
13e ZIP CODE 46394	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	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 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10 12) College (1 4 or 5 +) 6	
18 FATHER'S NAME (First Middle Last) MARTIN KOWAL			19 MOTHER'S NAME (First Middle Maiden Surname) MARY POSPYCHALA			
20a INFORMANT'S NAME (Type/Print) MRS. JANET M. DUNNING			20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 49425 DUNNING RD, OAKRIDGE, OR 97463/		20c Relationship DAUGHT	
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) NOVEMBER 2, 1999 HOLY CROSS CEMETERY			21c LOCATION—City or Town State CALUMET CITY, IL	
22a EMBALMER'S NAME MARTIN A. DYBEL		22b EMBALMER'S LICENSE NO FDE01019456		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Martin A. Dybel</i>		24b LICENSE NUMBER (of Licenses) FDE01019456		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME BARAN & SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394		
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 <u>Brain Tumor</u> DUE TO (OR AS A CONSEQUENCE OF)						
Conditions if any which gave rise to the immediate cause stating the underlying cause (a)						
b DUE TO (OR AS A CONSEQUENCE OF)						
c DUE TO (OR AS A CONSEQUENCE OF)						
d						
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) N/A	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 <input checked="" 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 (Check only one) <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 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>Donald J. Serrudo M.D.</i>				29c MEDICAL LICENSE NO 19183	29d DATE SIGNED (Month Day Year) NOV. 1, 1999	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type/Print) RON FELDNER, M.D., 110 RIDGE ROAD, MUNSTER, INDIANA 46321						
31 HEALTH OFFICER'S SIGNATURE <i>Donald J. Serrudo M.D.</i>					32 DATE FIED (Month Day Year) November 1, 1999	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <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)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc				