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2000-036522  
2000 0365

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

# TICOR TITLE INSURANCE

MORRIS W. CARTER  
RECORDER  
AFFIDAVIT

STATE OF INDIANA )  
COUNTY OF LAKE ) SS:

Wanda Bodnar, being first duly sworn upon oath, deposes and says:

1. That John S. Bodnar died on NOV 30, 1997 at Hammond Indiana.

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

The West 35 feet of Lot 22 and the East 20 feet of Lot 21, Block 2, 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.  
26-36-94-21

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.

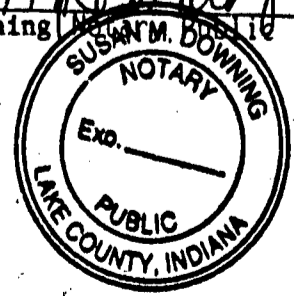
4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

*Wanda Bodnar*

Subscribed and sworn to before me, a Notary Public, this 19th day of May, 2000.

*Susan M. Downing*  
Susan M. Downing, Notary Public



My Commission expires:

4/10/07

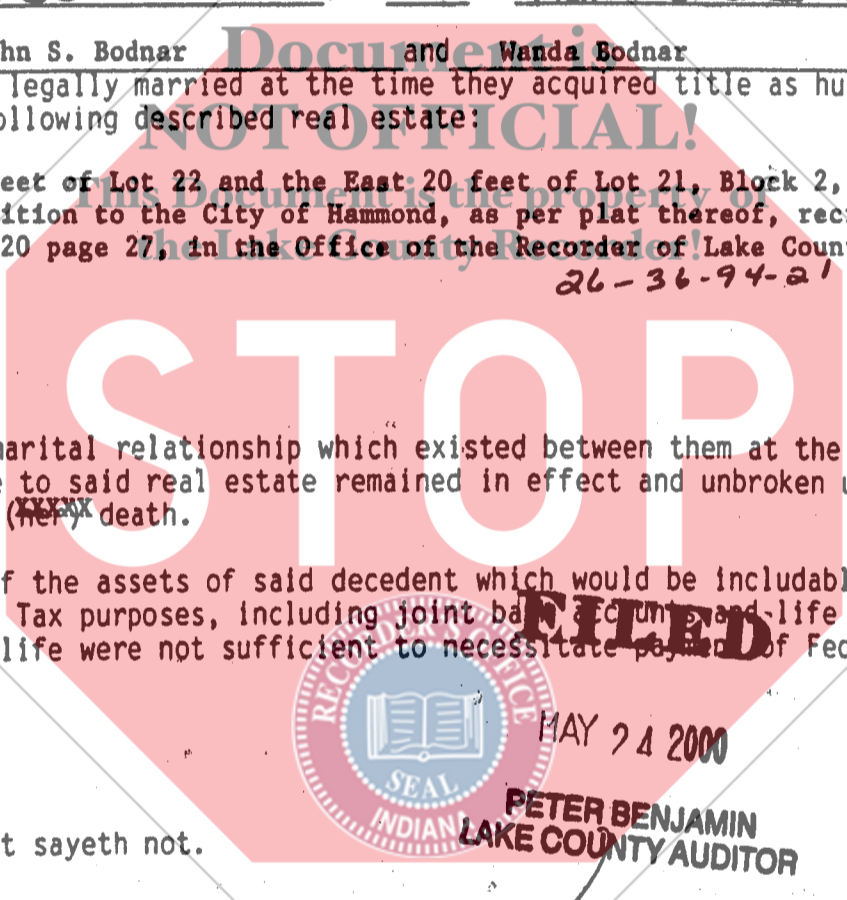
County of Residence:

Lake

This Instrument prepared by Wanda Bodnar

02438

920001623  
TICOR TITLE INSURANCE  
No Commission Indiana



\* 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

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

CERTIFICATE OF DEATH

Local No. 943

1 MAY 23, 1999 Date Issued *Franklin S. Remuda* Hammond Health Commissioner

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) <b>JOHN STEPHAN BODNAR</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>3:05 AM</b>	3b DATE OF DEATH (Month Day Year) <b>November 30, 1997</b>
4 SOCIAL SECURITY NUMBER <b>312-10-8682</b>	5a AGE—Last Birthday (Years) <b>80</b>	5b LIFELINE YEAR Months Days	5c LIFELINE DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>June 21, 1917</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>East Chicago, Indiana</b>	8a WAS DECEDENT A US VETERAN? <b>NO</b>	8b YEAR LAST SERVED IN US ARMED FORCES? <b>N/A</b>	9a PLACE OF DEATH (Check only one and see instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence	
9b FACILITY NAME (If not institution give street and number) <b>7226 Tilly Drive</b>		9c CITY, TOWN OR LOCATION OF DEATH <b>Hammond</b>	9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife give maiden name) <b>Wanda Sowinski</b>	12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Truck Driver</b>	12b KIND OF BUSINESS/INDUSTRY <b>McKeown Trans. Co.</b>	
13a RESIDENCE—STATE <b>Indiana</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>Hammond</b>	13d STREET AND NUMBER <b>259-174th Street</b>	
13e ZIP CODE <b>46324</b>	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc.)
16 FATHER'S NAME (First Middle Last) <b>Charles Bodnar</b>		17 MOTHER'S NAME (First Middle Maiden Surname) <b>Elizabeth Payer</b>		
18 INFORMANT'S NAME (Type/Print) <b>Wanda Bodnar</b>		19 MARITAL ADDRESS (Street and Number or Rural Route Number, City or Town, State ZIP Code) <b>259-174th Street, Hammond, Indiana 46324</b>		20 Relationship <b>Wife</b>
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input type="checkbox"/> Burial <input checked="" 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) <b>December 3, 1997 Heritage Crematory</b>		21c LOCATION—City or Town, State <b>Porter, Indiana</b>
22a EMBALMER'S NAME <b>None</b>		22b EMBALMER'S LICENSE NO. <b>N/A</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Dea L. Wagon</i>		24b LICENSE NUMBER (of Licensee) <b>8800057</b>	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Solan Funeral Home FI183002893 7109 Calumet Ave., Hammond, IN. 46324</b>	
26 PART I Enter the disease, 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. <b>LYMPHOMA</b> <i>Months</i> b. <b>CHRONIC OBSTRUCTIVE PULMONARY DIS</b> <i>Years</i> c. <b>HYPERTENSIVE CARDIOVASCULAR DIS</b> <i>Years</i>				
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) <b>NO</b>	28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>
29a CERTIFIER (Check only one) <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. <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>Claude A. Foreit, Dr.</i>			29c MEDICAL LICENSE NO. <b>02001161</b>	29d DATE SIGNED (Month Day Year) <b>December 1, 1997</b>
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) <b>Claude A. Foreit, Dr. 3831 Holman Ave., Hammond, Indiana 46327 931-1960</b>				
31 HEALTH OFFICER'S SIGNATURE <i>Franklin S. Remuda, M.D.</i>				32 DATE FILED (Month Day Year) <b>December 2, 1997</b>
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 <input type="checkbox"/> 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)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian, etc		

Reading #10 92001623

36-94-21

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