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# TICOR TITLE INSURANCE

MORRIS W. CARTER  
RECORDER

## AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

Shannon Stiener, being first duly sworn upon oath, deposes and says:

1. That Michael J. Kaminsky died on September 25, 1999 at Hammond, Indiana.

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

The North 1/2 of Lot 18 in Block 5 in Agnes Roberts Subdivision, as per plat thereof, recorded in Plat Book 2 page 20, in the Office of the Recorder of Lake County, Indiana.

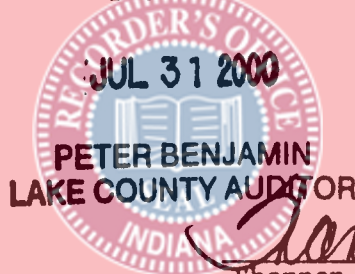
Key No. 35-296-28. **This Document is the property of the Lake County Recorder!**

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 effect payment of Federal Estate Tax.

Further affiant sayeth not.



Shannon Stiener

Subscribed and sworn to before me, a Notary Public, this 20th day of July, 2000, 1900.

Susan M. Charlebois  
Notary Public  
Susan M. Charlebois

My Commission expires:

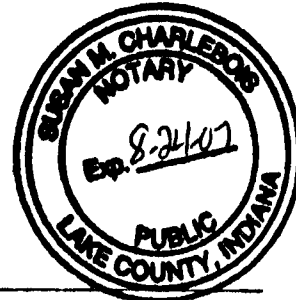
8-24-07

County of Residence:

Lake

This Instrument prepared by Shannon Stiener

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1100  
Ed.  
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\* ATTENTION: 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.

Local No. 774

CERTIFICATE OF DEATH

Sept. 28, 1999  
Date Issued  
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>MICHAEL J. KAMINSKY</b>		2 SEX <b>MALE</b>		3a TIME OF DEATH <b>3:26P</b>		3b DATE OF DEATH (Month Day Yr.) <b>SEPTEMBER 25, 1999</b>	
4 SOCIAL SECURITY NUMBER <b>316-03-7402</b>		5a AGE—Last Birthday (Years) <b>80</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo Day Yr.) <b>SEPT. 15, 1919</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>WHITING, INDIANA</b>					
8a WAS DECEDENT A U.S. VETERAN? <b>YES</b>		8b YEAR LAST SERVED IN US ARMED FORCES? <b>1945</b>		9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> 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) <b>1628 MYRTLE AVENUE</b>			9c CITY TOWN OR LOCATION OF DEATH <b>HAMMOND</b>		9d COUNTY OF DEATH <b>LAKE</b>		
10 MARITAL STATUS <b>WIDOWED</b>		11 SURVIVING SPOUSE (If wife give maiden name) <b>NONE</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>HEAVY OILS</b>		12b KIND OF BUSINESS/INDUSTRY <b>AMOCO OIL COMPAN</b>	
13a RESIDENCE—STATE <b>INDIANA</b>		13b COUNTY <b>LAKE</b>		13c CITY TOWN OR LOCATION <b>HAMMOND (WHITING P.O.)</b>		13d STREET AND NUMBER <b>1628 MYRTLE AVENUE</b>	
13e ZIP CODE <b>46394</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15 WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban Mexican Puerto Rican etc)	
13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16 RACE—American Indian Black White etc (Specify) <b>WHITE</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) <b>7</b>			
18 FATHER'S NAME (First Middle Last) <b>ANDREW KAMINSKY</b>			19 MOTHER'S NAME (First Middle Maiden Surname) <b>ANNA KAMINSKY</b>				
20a INFORMANT'S NAME (Type/Print) <b>MR. DONALD KAMINSKY</b>			20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) <b>215 GREGORY, MUNSTER, IN 46321</b>			20c Relationship <b>SON</b>	
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input 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) <b>SEPTEMBER 29, 1999 ST. JOHN CEMETERY</b>			21c LOCATION—City or Town State <b>HAMMOND, INDIANA</b>	
22a EMBALMER'S NAME <b>MARTIN A. DYBEL</b>			22b EMBALMER'S LICENSE NO <b>FDE01019456</b>		23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Martin A. Dybel</i>			24b LICENSE NUMBER (of Licensee) <b>FDE01019456</b>		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>BARAN &amp; SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394</b>		
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. <i>Acute Myocardial Infarction</i>							<i>Nil</i>
b. <i>Acute Stenosis</i>							<i>YRS</i>
c. <i>Coronary artery disease</i>							<i>YRS</i>
d. <i>C.O.P.D.</i>							<i>YRS</i>
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>N/A</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>N/A</b>	
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							
<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>John J. Larvin D.O.</i>				29c MEDICAL LICENSE NO <b>02000216B</b>		29d DATE SIGNED (Month Day Year) <b>SEPT. 27, 1999</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>WILLIAM V. GARVIN, D.O., 1010-119TH STREET, WHITING, INDIANA 46394</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Franklin J. Prevede M.D.</i>						32 DATE FILED (Month Day Year) <b>September 28, 1999</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"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month Day Year)		34b TIME OF INJURY		34c INJURY AT WORK? (Yes or no)	
		34d PLACE OF INJURY—At home farm street factory office building etc (Specify)		34e DESCRIBE HOW INJURY OCCURRED			
34g DATE PRONOUNCED DEAD (Month Day Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc					