

STATE OF INDIANA  
LAKE COUNTY  
FILED

2000 055112

2000 AUG -3 AM

MORRIS W. [unclear]  
RECORDER

AFFIDAVIT

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

JOANNE L. BAFALOUKOS, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, ANDREW P. BAFALOUKOS died ~~XXXXXX~~ (leaving a will) on July 2, 1999 at 10010 Northcote Ct, St. John, IN 46373

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

LOT 159 IN HOMESTEAD ACRES 7TH ADDITION TO THE TOWN OF ST. JOHN, IN AS PER PLAT THEREOF, RECORDED DECEMBER 11, 1978 IN BOOK 49 PAGE 126, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

COMMONLY KNOWN AS: 10010 NORTHCOTE COURT, ST. JOHN, IN 46373

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.

COMMUNITY TITLE COMPANY

FILE NO 817389 SU

Joanne L. Bafaloukos  
JOANNE L. BAFALOUKOS

Subscribed and sworn to before me, a Notary Public, this 24th day of July, 2000.

Karen Gatons  
Notary Public

THIS INSTRUMENT PREPARED BY: PATRICK J. MCMANAMA, Attorney at Law  
Identification No: 9534-45

KAREN GATONS  
Notary Public, State of Indiana  
County of Lake  
My Commission Expires 11/04/2006

01881

11/00  
AC

\* 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

State No. ....

Local No. 1565-99

269760  
TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

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

1 DECEASED—NAME (First, Middle, Last) <b>Andrew Bafaloukos</b>		2 SEX <b>Male</b>	3a TIME OF DEATH <b>12:55P</b>	3b DATE OF DEATH (Month, Day, Yr) <b>July 2, 1999</b>
4 SOCIAL SECURITY NUMBER <b>307-60-2543</b>		5a AGE—Last Birthday (Year) <b>47</b>	5b UNDER 1 YEAR Months Days <b>None</b>	5c UNDER 1 DAY Hours Minutes <b>None</b>
6 DATE OF BIRTH (Mo, Day, Yr) <b>Feb. 29, 1952</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Gary, IN</b>		
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>None</b>	9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA 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>10010 Northcote Ct.</b>		9c CITY, TOWN OR LOCATION OF DEATH <b>St. John</b>	9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS (Specify) <b>Married</b>	11 SURVIVING SPOUSE (If wife, give maiden name) <b>Joanne Lulias</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Safety Coordinator</b>	12b KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
13a RESIDENCE—STATE <b>IN</b>	13b COUNTY <b>Lake</b>	13c CITY, TOWN OR LOCATION <b>St. John</b>	13d STREET AND NUMBER <b>10010 Northcote Ct.</b>	
13e ZIP CODE <b>46373</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? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <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 (10-12) <b>—</b> College (1-4 or 5+) <b>—</b>		18 FATHER'S NAME (First, Middle, Last) <b>Gust Bafaloukos</b>		
19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Stamtia (Toula) Andriotis</b>		20a INFORMANT'S NAME (Type, Print) <b>Joanne Bafaloukos</b>		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10010 Northcote Ct., St. John, IN 46373</b>		20c Relationship <b>Wife</b>		
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>July 6, 1999 Elmwood Cemetery</b>		21c LOCATION—City or Town, State <b>Hammond, IN</b>
22a EMBALMER'S NAME <b>Brian T. Burns</b>		22b EMBALMER'S LICENSE NO. <b>8601763</b>	23 WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b LICENSE NUMBER (of Licensee) <b>1045184</b>	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321</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. IMMEDIATE CAUSE (Final disease or condition resulting in death) a <b>HEPATO Cellular Carcinoma</b> <span style="float: right;">2 mos</span> DUE TO (OR AS A CONSEQUENCE OF) 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)		28a WAS AN AUTOPSY PERFORMED? (Yes or no)	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
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) as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>Alexander S. Williams MD</i>		
29c MEDICAL LICENSE NO. <b>01047261</b>		29d DATE SIGNED (Month, Day, Year) <b>July 2, 1999</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print) <b>A. Michael Kemp 2450 169th Hammond, IN 46324</b>				
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>				32 DATE FILED (Month, Day, Year) <b>July 2, 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 LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>OCT 29 1999</b>		
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc. <i>Alexander S. Williams MD</i> LAKE COUNTY HEALTH COMM <b>10/29/99</b>		