(2)

60-31430

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

2000 061830

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 AUG 25 AM 9:57

JOHN W. CARTER
RECORDER

Chicago Title Insurance Company

AFFIDAVIT OF SURVIVORSHIP AND HEIRSHIP

Comes now the Affiant JOLETTA JAN PELLETIER, and being first duly sworn on oath did say that:

1. That she is an adult who has been a lifelong resident of Lake County, Indiana, has personal knowledge and is familiar with the affairs of her family and relationships therein;

2. That she is the daughter of JOHN A. FALDA, deceased, who died testate on January 17, 2000, in Lake County, Indiana;

3. That at the time of his death he was the surviving joint tenant of Dorothy S. Falda, deceased, who died on May 18, 1990, in Lake County, while married and never divorced from John A. Falda;

4. That John A. Falda, had two (2) children, Namely, Joletta Jan Pelletier and Richard M. Falda, who both survive him;

5. That Affiant, Joletta Jan Pelletier and Richard M. Falda are the sole surviving heirs to John A. Falda, deceased, each having a one-half interest in said estate consisting of the following described real estate located in Lake County, Indiana, to-wit:

Lot 27 and the South 15 feet of Lot 28 in Block 1, Douglas Park Manor, in the City of Hammond, as per plat thereof, recorded in Plat Book 17 page 26, in the Office of the Recorder of Lake County, Indiana. Commonly known as 3848 Hohman Avenue, Hammond, Indiana.

6. That the value of the gross estate, wherever located, less liens, encumbrances, and expenses does not exceed the inheritance tax exemptions available to said heirs and there is no inheritance tax due thereon;

FILED
AUG 24 2000
PETER BENJAMIN
LAKE COUNTY AUDITOR

7. That no application or petition for appointment of a personal representative is

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pending or has been granted or is contemplated in any jurisdiction; and

8. That there is no Federal Estate Tax due and payments to all creditors, estate expenses and expenses of decedent's last illness have all been paid and/or satisfied, leaving no debts due or owing thereon.

Affiant further saith not.

Joletta Jan Pelletier

Joletta Jan Pelletier

Subscribed and sworn to before me, a Notary Public this 21st day of August, 2000.

John A. DeMato

Notary Public

JOHN A DEMATO
Resident of Lake County

My Commission expires:

04/06/08

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Local No. 440

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

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

May 22, 1990 — Franklin D. Jemudion
Date Issued — Hammond Health Commissioner

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Dorothy S. Falda
2. SEX: Female
3a. TIME OF DEATH: 6:03 PM
3b. DATE OF DEATH (Month, Day, Yr.): May 18, 1990
4. SOCIAL SECURITY NUMBER: 498-05-4908-A
5a. AGE—Last Birthday (Years): 69
5b. UNDER 1 YEAR (Months, Days):
5c. UNDER 1 DAY (Hours, Minutes):
6. DATE OF BIRTH (Mo. Day. Yr.): May 4, 1921
7. BIRTHPLACE (City and State or Foreign Country): St. Louis, Missouri
8a. WAS DECEDENT A U.S. VETERAN?: No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: —
8c. PLACE OF DEATH (Check only one. See instructions): ☒ Hospital — Inpatient; ☐ ER/O (pat. pri.); ☐ DOA; ☐ Other — ☐ Nursing Home; ☐ Other (Specify); ☐ Residence
8d. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
8e. CITY, TOWN, OR LOCATION OF DEATH: Hammond
8f. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): John Falda
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Instructor
12b. KIND OF BUSINESS/INDUSTRY: Ceramic Shop
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 3848 Hohman Avenue
13e. ZIP CODE: 46327
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): White
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): Nicholas Chabdaratz
19. MOTHER'S NAME (First, Middle, Maiden Surname): Sylvia Petrovich

INFORMANT

20a. INFORMANT'S NAME (Type/Print): John Falda
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3848 Hohman Avenue, Hammond, In 46327
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) ☐ Entombment
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): May 21, 1990 Holy Cross Cemetery
21c. LOCATION—City or Town, State: Calumet City, Illinois
22a. EMBALMER'S NAME: Keith D. Anthony
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D. Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Anthony & Dziadowicz FH 83002835, 4404 Cameron, Hammond, In 46327

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. Massive Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
b. Gangrenous Small and Large Bowel
DUE TO (OR AS A CONSEQUENCE OF):
c. Superior Mesenteric Artery Embolism
DUE TO (OR AS A CONSEQUENCE OF):
d. Small Bowel Obstruction

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): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): 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: [signature]
29c. MEDICAL LICENSE NO.: 824
29d. DATE SIGNED (Month, Day, Year): 5/19/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Dr. L. Rosenberg 5500 Hohman Avenue Hammond, Indiana 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Jemudion M.D.
32. DATE FILED (Month, Day, Year): MAY 21 1990

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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.:

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1

100

* 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. 10

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

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

Jan 21, 2000
Date Issued

Hammond Health Commissio

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First, Middle, Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
JOHN	A.	FALDA	MALE	2:28A M	JANUARY 17, 2000

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)
313-01-4125	86			JAN. 29, 1913	WHITING, INDIANA

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9 PLACE OF DEATH (Check only one. See instructions)
YES	1946	HOSPITAL [X] 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
ST. MARGARET MERCY HEALTHCARE CENTER	HAMMOND	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
WIDOWED	NONE	MACHINIST	AMOCO OIL COMPA

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	3848 HOHMAN AVENUE

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)	
46327	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] 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)
JOHN FALDA	SOPHIE WIERZBYCKI

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
MRS. JOLETTA PELLETIER	1641 STANTON, WHITING, IN 46394	DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Donation [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Other (Specify)	JANUARY 20, 2000 HOLY CROSS CEMETERY	CALUMET CITY, ILL.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
HENRY J. BLAKE	FDE01019406	[ ] No [X] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
Walter J. Dyer	FDE01019456	BARANN SON, INC., FDH83007267 1235-119TH, WHITING, IN 46394

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. Acute Myocardial Infarction	
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)
	N/A	NO	N/A

CERTIFIER

29a CERTIFIER (Check only one)
[X] 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, Yr.)
[signature]	01031704	JAN. 20, 2000

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 26) (Type/Print)
PRAKASH MAKAM, M.D., 9122 COLUMBIA AVENUE, MUNSTER, INDIANA 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month, Day, Year)
Franklin D. Brenneke M.D.	January 21, 20

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				

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.

SDH08.004 State Form 10110 (R4/2-92) Duplicate/DO-1