STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2000 076537

2000 OCT 20 AM 9:56

MORRIS W. CARTER
RECORDER

Chicago Title Insurance Company

COM # 620004334

SURVIVORSHIP AFFIDAVIT

On this _____ (insert date) before me personally appeared SALLY IRENE BALDIN

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;

2. Affiant is OWNER ; (state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Joseph J. Baldin and Sally Irene Baldin ;

4. Said Joseph J. Baldin A/k/a Joseph John Baldin (fill in name of co-tenant who died)

died on X May 21, 2000

leaving X a will; (insert "a" or "no"; if will left, attach a copy)

5. The legal description of the premises in question is:

Lot 22 in Timberlane Unit 1-A, an Addition to the Town of St. John, as per plat thereof, recorded in PB 44 p 5, in the Office of the Recorder of Lake Co., Ind.

FILED

OCT 19 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

6. Is there Federal Estate or State Inheritance tax liability by reason of the death of said decedent? ☐ Yes ☒ No

If yes, then estimated taxes due are $ _____.

The taxes due are ☐ paid or ☐ unpaid.

01544

13-

(7) Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

No

(If answer is "Yes," identify the divorce proceedings:

);

(8) Affiant's relationship to the deceased was Wife

Signature: Sally Irene Baldin
Sally Irene Baldin

Printed Name: Sally Irene Baldin

Address: 12101 W. 90th Ay.

St. John, IN. 46373

Subscribed and sworn to before me by the affiant

this OCTOBER 16, 2000
(Insert date)

Sophie Zdraveski
Notary Public

Printed Name SOPHIE ZDRAVESKI

My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires: March 5, 2008

My Commission Expires

This Instrument prepared by

ATTENTION ESTATE: The Social Security # is ing requested by this state agency in order to ursue its statutory responsibility. Disclosure is luntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Local No. 1200-CC State No. .....

392637

YPE/PRINT IN ERMANENT LACK INK

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

1 DECEASED—NAME (First Middle Last)			2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Joseph	John	Baldin	Male	5:05A M	May 21, 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)
304-32-8384	67			Nov. 13, 1932	East Chicago, In

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one See instructions)
Yes	1956	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
Community Hospital	Munster, In.	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
Married	Sally Irene MacDonald	CEO Financial Inst.	Credit Union

13a RESIDENCE—STATE	13b COUNTY	13c CITY TOWN OR LOCATION	13d STREET AND NUMBER
Indiana	Lake	St. John	12101 W. 90th Ave.

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) Elementary/Secondary (0 12)	College (1 4 or 5)
46373	[ ] No [X] Yes	[X] No [ ] Yes	USA	[X] No [ ] Yes	White	12	4

18 FATHER'S NAME (First Middle Last)	19 MOTHER'S NAME (First Middle Maiden Surname)
Emil Baldin	Margaret Basso

20a INFORMANT'S NAME (Type Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code)	20c Relationship
Paula Roesel	16365 Lakewood Street Lowell, In. 46356	Daughter

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place)	21c LOCATION—City or Town State
[ ] Burial [X] Cremation [ ] Removal from State [ ] Donation [ ] Other (Specify)	May 23, 2000 Regional Cremation Service	Munster, In.

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
N/A	N/A	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME
James F Belarski	FD09200077	Elmwood Chapel FHD#19900052 11300 W. 97th Lane St. John, In.

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 Limit only one cause on each line

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a Advanced carcinoma colon with liver mets	
DUE TO (OR AS A CONSEQUENCE OF)	b	
DUE TO (OR AS A CONSEQUENCE OF)	c	
DUE TO (OR AS A CONSEQUENCE OF)	d	

Conditions if any which gave rise to the immediate cause stating the underlying cause last

PART II Other significant conditions contributing to death but not resulting in the underlying cause given 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)
No	Yes	

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) and manner 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 Year)
[signature]	29782	5-22-00

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type Print)

31 HEALTH OFFICER'S SIGNATURE	32 DATE FILED (Month Day Year)
Alexander D Hellmuth MD	May 23, 2000

33 MANNER OF DEATH	34a DATE OF INJURY	34b TIME OF INJURY	34c INJURY AT WORK?	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

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1