



Chicago Title Insurance Company

62-14403LD

SURVIVORSHIP AFFIDAVIT

STATE OF

COUNTY OF

S. S.

2002 019961

On this Feb 20, 2002 before me personally appeared

Joseph Macko

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, personal representative of OLSA C. MACKO dec'd.

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by OLSA C. MACKO and JOSEPH M. MACKO, SR.

4. Said JOSEPH M. MACKO, SR. died on APRIL 14, 1993 leaving NO will.

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

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent:

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 SON

Signature: Joseph M. Macko

Address: 4005 FIR EAST CHICAGO, IND

Subscribed and sworn to before me by the affiant

this 2-20-02 Katherine E. Adams Notary Public

KATHERINE E. ADAMS Notary Public, State of Indiana County of Lake My Commission Expires Dec 13, 2008

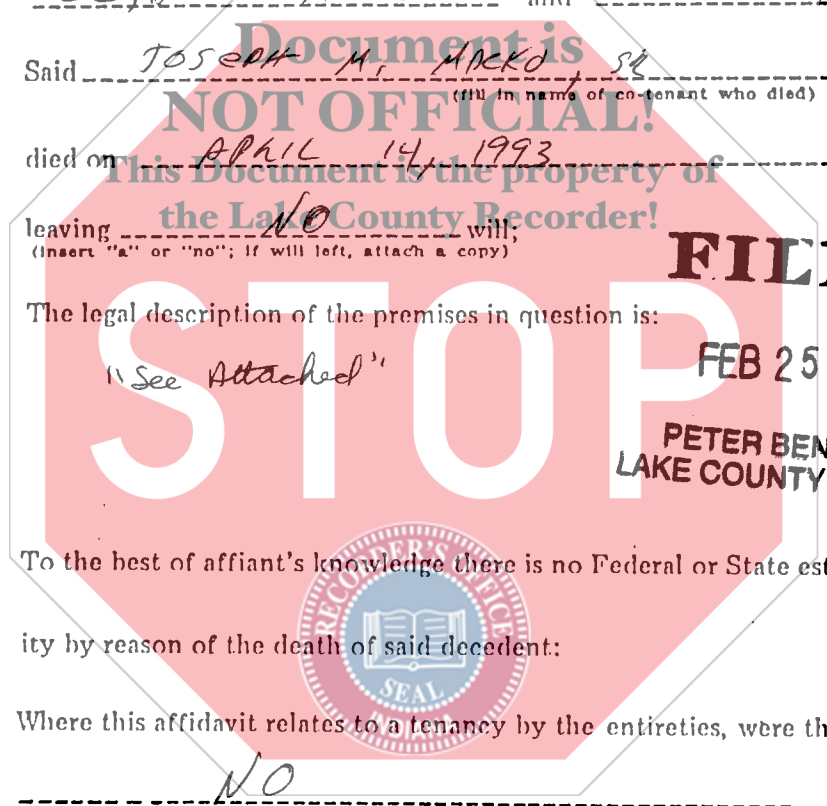
My Commission Expires

This instrument prepared by Joseph M. Macko

001472

Handwritten initials and date: 14.02 AR CT

Chicago Title Insurance Company



LEGAL DESCRIPTION

Lots 15, 16 and 17 in Block 5 in Subdivision of the Southwest 1/4 of Section 28, Township 37 North, Range 9 West of the Second Principal Meridian, in the City of East Chicago, as per plat thereof, recorded in Plat Book 2 page 25, in the Office of the Recorder of Lake County, Indiana.



INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 113

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

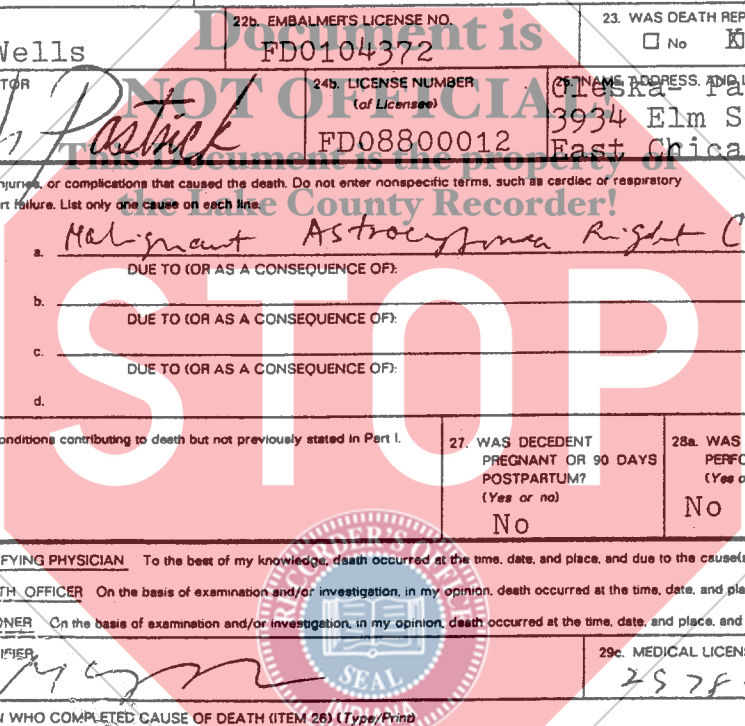
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CRONER
SE ONLY

1. DECEASED—NAME (First, Middle, Last) Joseph M. Macko, Sr.				2. SEX Male		3a. TIME OF DEATH 11:10^P		3b. DATE OF DEATH (Month, Day, Yr.) April 14, 1993	
4. SOCIAL SECURITY NUMBER 306-03-8916		5a. AGE—Last Birthday (Years) 76		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo. Day, Yr.) October 30, 1916	
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1953		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) Residence		
9b. FACILITY NAME (If not institution, give street and number) 4005 Fir				9c. CITY, TOWN, OR LOCATION OF DEATH East Chicago			9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Olga Dunder		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Machinest			12b. KIND OF BUSINESS/INDUSTRY Combustion Engeneri		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION East Chicago			13d. STREET AND NUMBER 4005 Fir		
13a. ZIP CODE 46312		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA		15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) 12		17. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) John Macko			19. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Swancara		
20a. INFORMANT'S NAME (Type/Print) Olgo Macko				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Fir East Chicago : Indiana				20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) April 17, 1993 Calumet Park Cemetery			21c. LOCATION—City or Town, State Merrillville, In.			
22a. EMBALMER'S NAME Charles W. Wells			22b. EMBALMER'S LICENSE NO. FD0104372			23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>David J. Pastick</i>			24b. LICENSE NUMBER (of Licensee) FD08800012			24c. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Cleska - Pastick Funeral Home 3934 Elm St #155 East Chicago, Indiana 46312			
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. Malignant Astrocytoma Right Cerebral hemisphere DUE TO (OR AS A CONSEQUENCE OF):									
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) 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	
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>[Signature]</i>						29c. MEDICAL LICENSE NO. 39782		29d. DATE SIGNED (Month, Day, Year) 4-16-93	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. M. Y. Ali 9116 Columbia Munster Indiana 46322									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>							32. DATE FILED (Month, Day, Year) 4-19-93		
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			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.					



FILE