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2002 042087

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Genny Rupp, being first duly sworn upon oath, deposes and says:

1. That Theresa G. Vrabel died on July 13, 19 93 at Hammond, Lake County, IN.

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

Lot 12 in Block 11 in Smith and Bader's Second West Park Addition to the City of Hammond, as per plat thereof, recorded in Plat Book 15 page 9, in the Office of the Recorder of Lake County, Indiana.

36-3/5-12

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.

Genny Rupp
Genny Rupp

Subscribed and sworn to before me, a Notary Public, this 30th day of April, 19 2002.

Denise K. Zawada
Notary Public

My Commission expires:
8/31/2006

County of Residence:
Lake

FILED
MAY 03 2002
PETER BENJAMIN
LAKE COUNTY AUDITOR

This Instrument prepared by Genny Rupp

922-1568
TICOR SO

11-

Local No. 616

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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

Jul 19 1993
Date Issued

Franklin D. Premuda
Hammond Health Commissioner

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): THERESA G. VRABEL
2. SEX: FEMALE
3a. TIME OF DEATH: 4:15 P.M.
3b. DATE OF DEATH (Month, Day, Yr.): JULY 13,1993
4. SOCIAL SECURITY NUMBER: 306-24-7729
5a. AGE—Last Birthday (Years): 78
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): APRIL 20,1915
7. BIRTHPLACE (City and State or Foreign Country): WHITING, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. FACILITY NAME (If not institution, give street and number): 2040 DAVIS AVENUE
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): ANDREW J. VRABEL
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOMEMAKER
12b. KIND OF BUSINESS/INDUSTRY: OWN HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HAMMOND (WHITING P.O.)
13d. STREET AND NUMBER: 2040 DAVIS AVENUE
13e. ZIP CODE: 46394
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
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): 9; College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): VENDELIN GABURIAK
19. MOTHER'S NAME (First, Middle, Maiden Surname): THERESA LUBJAK

INFORMANT

20a. INFORMANT'S NAME (Type/Print): MR. ANDREW J. VRABEL
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2040 DAVIS AVE., WHITING, IN 46394
20c. Relationship: HUSBAND

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JULY 16,1993 ST. JOHN CEMETERY
21c. LOCATION—City or Town, State: HAMMOND, INDIANA
22a. EMBALMER'S NAME: MARTIN A. DYBEL
22b. EMBALMER'S LICENSE NO.: FDE01019456
23. WAS DEATH REPORTED TO CORONER?: ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Martin A. Dybel
24b. LICENSE NUMBER (of Licensee): FDE01019456
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BARAN & SON, INC., FDH83007267 1235-119TH ST., 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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Carcinoma of Tail
DUE TO (OR AS A CONSEQUENCE OF):
b. Esophageal & hepatic Metastasis
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

Approximate Interval Between Onset and Death: 18 mos

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): N/A

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: Lowell H. Steen M.D.
29c. MEDICAL LICENSE NO.: 01015522
29d. DATE SIGNED (Month, Day, Year): JULY 16,1993
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): LOWELL H. STEEN, M.D., 3641 RIDGE ROAD, HIGHLAND, INDIANA 46322

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Premuda M.D.
32. DATE FILED (Month, Day, Year): July 19,1993

CORONER USE ONLY

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.: