

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2002 062773

2002 JUL 12 AM 8:46



TICOR TITLE INSURANCE

MORRIS W. CARTER
RECORDER

SURVIVORSHIP AFFIDAVIT

Key # 15.364.13(8)

STATE OF: Indiana)
) SS:

COUNTY OF: Porter)
On this July 8, 2002

Before me personally appeared Dorothy R. Santolino

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

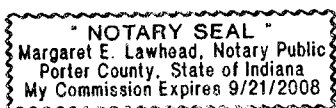
- Affiant resides at the address given below affiant's signature;
- Affiant is Dorothy R. Santolino
(state interest of affiant in the above premises as owner)
- Said premises described as follows: Lot 13 in Bon Aire Subdivision Unit No. 3 in the Town of Merrillville as per plat thereof recorded in Plat Book 35 page 73 in the Office of the Recorder of Lake County, Indiana.
5980 Taft Street Merrillville IN 46410
- Said premises were formerly owned as joint tenants or as tenants by entireties by Joseph Luptak and Dorothy R. Santolino
- Said Joseph Luptak
(fill in name of co-tenant who died)
died on 11-7-01
leaving A will;
(insert "a" or "no" if a will has been left, attach a copy)
- The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of \$ 600,000.00 and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of the said decedent:
- Where this affidavit relates to a tenancy of the entireties, were the parties ever divorced? NO
(If answer is YES, identify the dissolution proceedings.)
- Affiant's relationship to the deceased was DAUGHTER

Signature Dorothy R. Santolino
Address: 389 N. 650 West Valparaiso, IN

State of Indiana)
County of Porter)

Before me, the undersigned, a Notary Public in and for said County and State, this July 8, 2002 personally appeared Dorothy R. Santolino

and acknowledged the execution of the foregoing Affidavit.



Margaret E. Lawhead
Notary Public Margaret E. Lawhead
Resident of _____ County
My Commission expires: _____

Prepared by: Dorothy R. Santolino

TICOR TITLE INSURANCE
Valparaiso, IN 46393
920022805

JUL 11 2002

000676

Handwritten initials and numbers: 11-7-01, M.A., J.S.

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to insure 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. 8742-01

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

Unit #08 Key #15-364-13 Bon Aire Sub Unit #3 hot 13

1 DECEASED—NAME (First Middle, Last) JOSEPH LUPTAK				2 SEX Male		3a TIME OF DEATH 12:40 AM		3b DATE OF DEATH (Month, Day, Yr) November 7, 2001						
4 *SOCIAL SECURITY NUMBER 306-09-3383		5a AGE—Last Birthday (Years) 91		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) January 17, 1910		7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana				
8a WAS DECEDENT A U.S. VETERAN? No		8b YEAR LAST SERVED IN U.S. ARMED FORCES? ---		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) <input checked="" type="checkbox"/> Residence										
9b FACILITY NAME (If not institution, give street and number) 5980 Taft Place						9c CITY, TOWN, OR LOCATION OF DEATH Merrillville			9d COUNTY OF DEATH Lake					
10 MARITAL STATUS (Specify) Widowed		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) Motor Inspector				12b KIND OF BUSINESS/INDUSTRY U.S. Steel						
13a RESIDENCE—STATE Indiana		13b COUNTY Lake		13c CITY, TOWN, OR LOCATION Merrillville			13d STREET AND NUMBER 5980 Taft Place							
13e ZIP CODE 46410		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? U.S.A.		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) 8 College (1-4 or 5+) ---				
18 FATHER'S NAME (First, Middle, Last) John Luptak						19 MOTHER'S NAME (First, Middle, Maiden Surname) Mary Mikula								
20a INFORMANT'S NAME (Type/Print) Dorothy Santolino				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 389 N 650 W, Valparaiso, IN 46385				20c Relationship Daughter						
21a METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) November 10, 2001 Calumet Park Cemetery				21c LOCATION—City or Town, State Merrillville, Indiana						
22a EMBALMER'S NAME Jonathon R. Christiansen				22b EMBALMER'S LICENSE NO. FI20100045		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes								
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b LICENSE NUMBER (of Licensee) 1009893		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME PRUZIN BROS. FUNERAL SERVICE #3002453 6360 Broadway, Merrillville, IN 46410								
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) Renal failure														
a DUE TO (OR AS A CONSEQUENCE OF) Hypertensive nephropathy														
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 Hypertensive nephropathy						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) ---				
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. 1026067		29d DATE SIGNED (Month, Day, Year) 11/9/01						
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Raymundo Billena, M.D., 5490 Broadway, Merrillville, IN 46410														
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>														
32 DATE FILED November 13, 2001														
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														
33a DATE OF INJURY (Month, Day, Year) 11/13/2001			33b TIME OF INJURY			33c INJURY AT WORK? (Yes or no)			33d DESCRIBE HOW INJURY OCCURRED ---					
34a PLACE OF INJURY (Home, farm, street, factory, office, building, etc. Specify) ---						34b LOCATION (Street and Number or Rural Route Number, City or Town, State)								
34g DATE PRONOUNCED DEAD (Month, Day, Year) NOVEMBER 13 2001														
34h SIGNATURE AND TITLE OF HEALTH OFFICER PETER BENJAMIN LAKE COUNTY AUDITOR														
34i IDENTIFICATION NUMBER 000677														