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TICOR TITLE INSURANCE

AFFIDAVIT

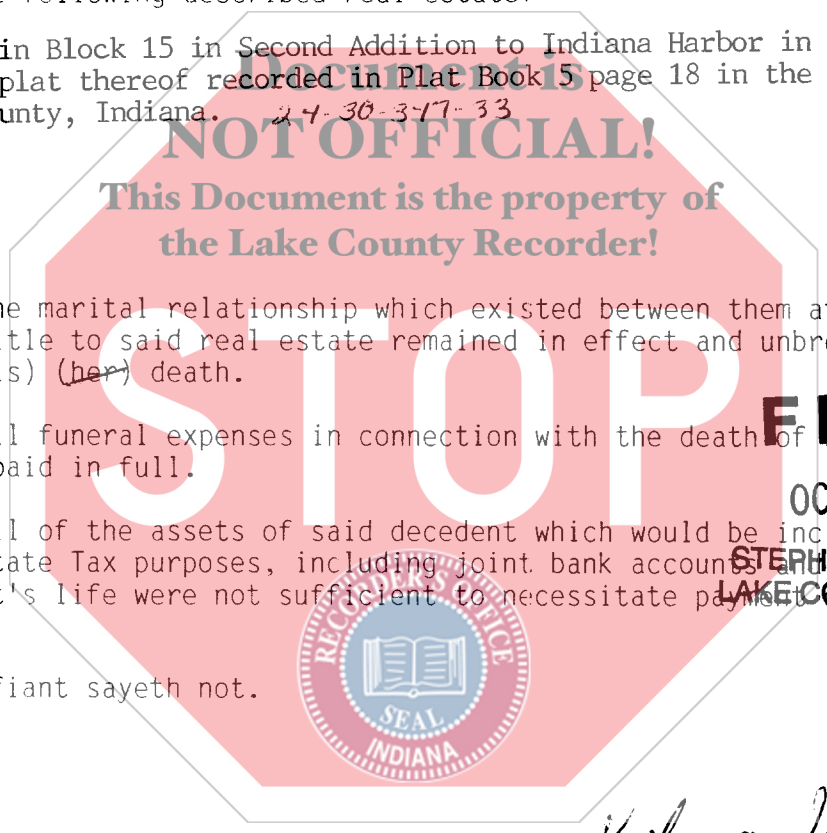
2003 105808

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

~~Philip J. Ignarski~~ Katina Kastouros, being first duly sworn upon oath, deposes and says:

1. That Panagiotes Kostouros a/k/a Peter Kostouros died on May 2, ~~19~~ 2003 at Community Hospital.
2. That Peter Kostouros a/k/a Panagiotes Kostouros and Katina Kastouros were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 33 in Block 15 in Second Addition to Indiana Harbor in the City of East Chicago as per plat thereof recorded in Plat Book 5 page 18 in the Office of the Recorder of Lake County, Indiana. 24-30-377-33



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.

Katina Kastouros
Katina Kastouros

Subscribed and sworn to before me, a Notary Public, this 30th day of September, ~~19~~ 2003.

Philip J. Ignarski
Philip J. Ignarski, Notary Public

PHILIP J. IGNARSKI
Notary Public, State of Indiana
Lake County
Commission Expires 03/17/04

My Commission expires:

County of Residence:

000187

This Instrument prepared by Katina Kastouros

TICOR CP 920037417

12⁰⁰ KM
T1

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 1163-03

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

PE/PRINT IN PERMANENT BLACK INK

DECEASED

MENTS

FORMANT

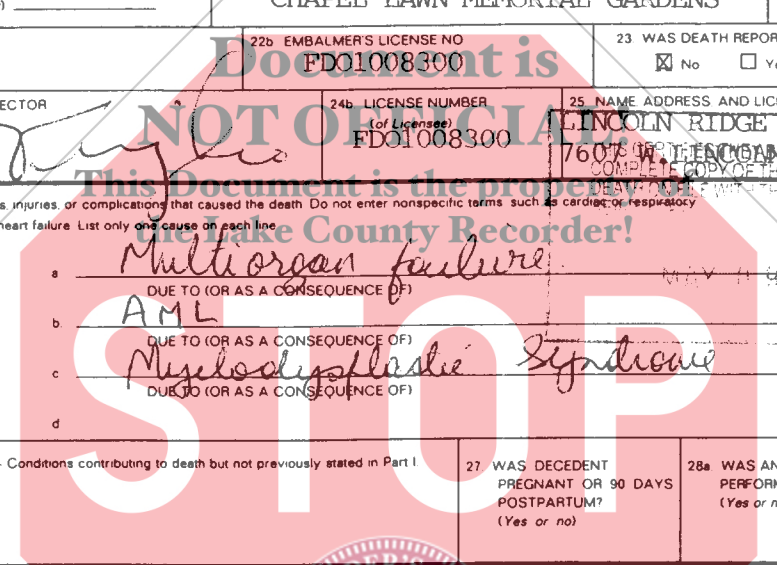
POSITION

USE OF THIS

OFFICER

OFFICER

1 DECEASED—NAME (First Middle Last) PETER KOSTOUROS			2 SEX MALE		3a TIME OF DEATH 6:15A M		3b DATE OF DEATH (Month Day Yr) MAY 2, 2003					
4 *SOCIAL SECURITY NUMBER 311-36-3224		5a AGE—Last Birthday (Years) 68		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo Day Yr) MARCH 25, 1935		7 BIRTHPLACE (City and State or Foreign Country) GREECE		
8a WAS DECEDENT A U.S. VETERAN? YES		8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1960		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence				
9b FACILITY NAME (If not institution, give street and number) COMMUNITY HOSPITAL					9c CITY, TOWN OR LOCATION OF DEATH MUNSTER			9d COUNTY OF DEATH LAKE				
10 MARITAL STATUS (Specify) MARRIED		11 SURVIVING SPOUSE (If wife, give maiden name) KATINA MOROS		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) STEEL WORKER				12b KIND OF BUSINESS/INDUSTRY INLAND STEEL COMPANY				
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY, TOWN OR LOCATION ST. JOHN			13d STREET AND NUMBER 10096 OLCOTT AVE.					
13e ZIP CODE 46373		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) 12 College (1-4 or 5+) _____		
18 FATHER'S NAME (First Middle Last) THEOFANIS KOSTOUROS					19 MOTHER'S NAME (First Middle Maiden Surname) VASILIKE KONDIKIS							
20a INFORMANT'S NAME (Type/Print) KATINA KOSTOUROS				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10096 OLCOTT AVE. ST. JOHN, IN. 46373				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) MAY 5, 2003 CHAPEL LAWN MEMORIAL GARDENS				21c LOCATION—City or Town, State SCHERERVILLE, INDIANA					
22a EMBALMER'S NAME eli vujko			22b EMBALMER'S LICENSE NO. FD01008300			23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a SIGNATURE OF FUNERAL DIRECTOR <i>Eli Vujko</i>			24b LICENSE NUMBER (of License) FD01008300			25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. TENCIGAN HWY. CROWN POINT, IN. 46307						
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. Multiorgan failure DUE TO (OR AS A CONSEQUENCE OF) b. AML DUE TO (OR AS A CONSEQUENCE OF) c. Myelodysplastic Syndrome DUE TO (OR AS A CONSEQUENCE OF) d. _____										Approximate Interval Between Onset and Death 3 weeks 1 yr		
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)			
29a CERTIFIER (Check only one) <input 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>K. Kalloni</i>						29c MEDICAL LICENSE NO. 01098359		29d DATE SIGNED (Month, Day, Year) OCT 2 2003		29e COUNTY SIGNED (Month, Day, Year) 5-7-03		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Kameswari Kalloni 800 MacArthur Blvd LAKE COUNTY AUDITOR Ste 12B												
31 HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>										32 DATE FILED (Month, Day, Year) May 9, 2003		
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			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.							



FILED

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