



**TICOR TITLE INSURANCE**

**SURVIVORSHIP AFFIDAVIT**

STATE OF: Indiana )  
 ) SS:  
COUNTY OF: Lake )

On this October 20, 2004 Before me personally appeared Joann Pavy

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

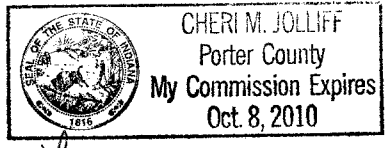
- Affiant resides at the address given below affiant's signature;
- Affiant is personal representative  
(state interest of affiant in the above premises as owner)
- Said premises described as follows: North 65.38 feet of South 67.38 feet of Lot 2 in Block 14 in Lake Kramer Jr Addn to Hobart as per plat thereof, recorded as AB 11, pg 22, in Office of Recorder of Lake County, Inc  
1336 Lincoln Street, Hobart, Indiana
- Said premises were formerly owned as joint tenants or as tenants by entireties by Albena Zukowski and Evelyn M Zukowski
- Said Evelyn M Zukowski  
(fill in name of co-tenant who died)  
died on February 14, 2004  
leaving no 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 \$ 70,000 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 sister

Signature: Joann Pavy  
Address: 4461 Park Ave  
Lake Station, IN 46405

State of Indiana )  
 )  
County of Lake )

Before me, the undersigned, a Notary Public in and for said County and State, this \_\_\_\_\_ personally appeared Joann Pavy

and acknowledged the execution of the foregoing Affidavit.



Cheri M Joliff  
Notary Public  
Resident of Porter County  
My Commission expires: Oct 8, 2010

Prepared by: Joann Pavy

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\* ATTENTION ESTATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.\*

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Local No. 414-04

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK	1. DECEASED - NAME (First, Middle, Last) Evelyn M. Zukowski				2. SEX Female	3a. TIME OF DEATH 10:25 AM	3b. DATE OF DEATH (Month, Day, Yr.) February 14, 2004
	4. SOCIAL SECURITY NUMBER 307-54-6695		5a. AGE - Last Birthday (Years) 57	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo., Day, Yr.) July 13, 1946	
DECEDENT	8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? —	PLACE OF DEATH (Check only one See instructions)				
	9b. FACILITY NAME (If not institution, give street and number) 1336 Lincoln Street		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		<input checked="" type="checkbox"/> Residence
PARENTS	9c. CITY, TOWN, OR LOCATION OF DEATH Hobart			9d. COUNTY OF DEATH Lake		9e. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Clerk	
	10. MARITAL STATUS (Specify) Never		11. SURVIVING SPOUSE (If wife, give maiden name) N/A		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Clerk		12b. KIND OF BUSINESS/INDUSTRY E. J. & E. Railroad
INFORMANT	13a. RESIDENCE - STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN OR LOCATION Hobart		13d. STREET AND NUMBER 1336 Lincoln Street
	13e. ZIP CODE 46342	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
DISPOSITION	17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A		18. FATHER'S NAME (First, Middle, Last) Martin Zukowski		19. MOTHER'S NAME (First, Middle, Maiden Surname) Albena Yurjevich		20. Relationship Sister
	20a. INFORMANT'S NAME (Type/Print) Joann Pavy		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401 Park Avenue, Lake Station, IN 46405				20c. Relationship Sister
CAUSE OF DEATH	21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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) February 18, 2004 NW Indiana Cremation Service		21c. LOCATION - City or Town, State Crown Point, Indiana		
	22a. EMBALMER'S NAME James F. Burns		22b. EMBALMER'S LICENSE NO. 01009461		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
HEALTH OFFICER	24a. SIGNATURE OF FUNERAL DIRECTOR <i>James F. Burns</i>		24b. LICENSE NUMBER (of Licensee) ED01009461		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns Funeral Home FH83002380 701 E. 7th Street, Hobart, Indiana 46342-		
	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. 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  Hypertensive Cardio-vascular Disease  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH FEB 17 2004  THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.						
CERTIFIER	PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I				27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) N		28a. WAS AN AUTOPSY PERFORMED? (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. 01027425		29d. DATE SIGNED (Month, Day, Year) 02/16/2004
HEALTH OFFICER	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Fernando Rivera M.D. 3099 Central Avenue, Lake Station, IN 46405						
	31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>						32. DATE FILED (Month, Day, Year) February 17, 2004
HEALTH OFFICER	33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		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) February 14, 2004			34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc.				

