

2006 108567

2006 NOV 13 12

MICHAEL A. COVANN  
RECORDER

23

**AFFIDAVIT OF JACOB J. BRASK**

I, JACOB J. BRASK, being duly sworn, affirm under the penalties for perjury that I am an adult under no mental or physical incapacity or disability and am competent to testify to the facts set forth in this Affidavit and state as follows:

1. I am the surviving spouse of Marjorie L. Brask, who died on or about the 9<sup>th</sup> day of August, 2006, in Merrillville, Indiana.

2. My wife and I owned real estate situated in Lake County, Indiana which is described as follows:

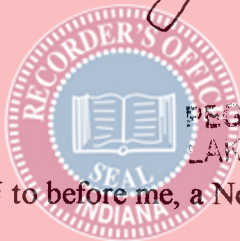
Lot 46, Southbrook Unit No. 1, as shown in plat book 38, page 74, in Lake County, Indiana.

Commonly known as 7410 Jennings Place, Merrillville, Indiana 46410.

3. As a result of my wife's death, I am the sole owner of the property described in the foregoing paragraph.

FURTHER AFFIANT SAYETH NOT

STATE OF INDIANA )  
                                  ) SS:  
COUNTY OF LAKE )



*Jacob J. Brask*  
JACOB J. BRASK

DEC 08 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

SUBSCRIBED AND SWORN to before me, a Notary Public, this 13<sup>th</sup> day of November, 2006.

*Maryann McCauley*  
Maryann McCauley, NOTARY PUBLIC

My Commission Expires: 10/05/08  
Resident of Lake County.

026615

15-  
31682  
31749  
20

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

*Maryann K. McCauley*  
Maryann K. McCauley



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

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. 60 PM

Local No. 1809-06

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

TYPE/PRINT IN PERMANENT INK

DECEDENT

INFORMANTS

INFORMANT

DISPOSITION

USE OF PATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>MARJORIE L. BRASK</b>				2 SEX <b>Female</b>		3a TIME OF DEATH <b>9:30 AM</b>		3b DATE OF DEATH (Month, Day, Yr) <b>August 09, 2006</b>			
4 *SOCIAL SECURITY NUMBER <b>347-14-7353</b>		5a AGE—Last Birthday (Years) <b>81</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) <b>February 05, 1925</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Illinois</b>	
8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence							
9b FACILITY NAME (If not institution, give street and number) <b>7410 Jennings Place</b>						9c CITY, TOWN, OR LOCATION OF DEATH <b>Merrillville</b>			9d COUNTY OF DEATH <b>Lake</b>		
10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Jacob J. Brask</b>			12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>			12b KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN, OR LOCATION <b>Merrillville</b>			13d STREET AND NUMBER <b>7410 Jennings Place</b>				
13e ZIP CODE <b>46410</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>		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) <b>White</b>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>	
18 FATHER'S NAME (First, Middle, Last) <b>Ragnar Carlson</b>						19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Clark</b>					
20a INFORMANT'S NAME (Type/Print) <b>Jacob J. Brask</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7410 Jennings Place, Merrillville, Indiana 46410</b>				20c Relationship <b>Husband</b>			
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) <b>August 14, 2006 Calvary Cemetery</b>				21c LOCATION—City or Town, State <b>Portage, Indiana 46368</b>			
22a EMBALMER'S NAME <b>Jonathon R. Christiansen</b>				22b EMBALMER'S LICENSE NO. <b>FD20200095</b>				23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR 				24b LICENSE NUMBER (of Licensee) <b>1009893</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>PRUZIN BROTHERS FUNERAL SERVICE Lic. # FH 83002453 6360 Broadway, Merrillville, Indiana, 46410</b>					
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. <b>a. Cardiorespiratory arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Daily chattering</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Progressive Dementia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>										Approximate Interval Between Onset and Death <b>Minutes</b> <b>Days</b> <b>Months</b>	
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) <b>NO</b>		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>	
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 								29c MEDICAL LICENSE NO. <b>0103371A</b>		29d DATE SIGNED (Month, Day, Year) <b>8-10-06</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Michael Kovacich 200 E. 80th Place, Suite 100 Merrillville, Indiana 46410 (219) 769-7536</b>											
31 HEALTH OFFICER'S SIGNATURE 										32 DATE FILED (Month, Day, Year) <b>August 10, 2006</b>	
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)		THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. <b>AUG 14 2006</b>			
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.							