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AFFIDAVIT

STATE OF INDIANA)
COUNTY OF LAKE) SS:

2007 046416

Dalia Martinkus, Vidas Nemickas, and Rimgaudas Nemickas, being first duly sworn upon oath, deposes and says:

1. That **Romualdas Nemickas**, died on the 15th Day of February 1991 at Munster, Lake County, Indiana.
2. That at the time of his death, he was co-owner as Joint Tenant with **Elena Nemickas, Dalia Martinkus, Vidas Nemickas, and Rimgaudas Nemickas** in the following described real estate:

LOT FIFTY-NINE (59) IN THE HIGHLAND TERRACE, FIFTH ADDITION TO THE TOWN OF HIGHLAND, LAKE COUNTY, INDIANA.

3. That no Federal Estate Tax or Indiana Inheritance Tax is due as a result of the death of **Romualdas Nemickas**.
4. That this Affiant's relationship to the Decedent were Siblings.

FURTHER, Affiant sayeth not.

Dalia Martinkus
Dalia Martinkus

Vidas Nemickas
Vidas Nemickas

R Nemickas

Rimgaudas Nemickas

COMMUNITY TITLE COMPANY
FILE NO L 37402

Subscribed and sworn to before me, a Notary Public this 30th day of May, 2007.

Karen Craig, Notary Public
My Commission Expires _____
County of Residence: _____



(PRINTED NAME)



This instrument prepared by **PATRICK J. McMANAMA**, Attorney-at-Law, Attorney ID No. 9534-45.
No legal opinion given or rendered. All information used in preparation

\$14
cm
CA

FILED

JUN - 6 2007

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

007471

INDIANA STATE BOARD OF HEALTH

Local No. 392-91

CERTIFICATE OF DEATH

State No.

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

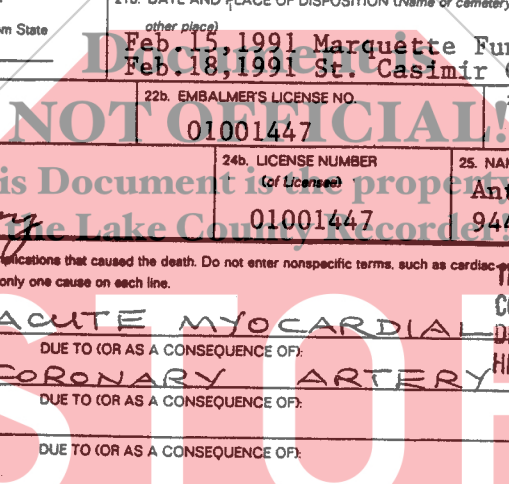
CAUSE OF
DEATH

CERTIFIER

HEALTH
OFFICER

CORONER
USE ONLY

1. DECEASED—NAME (First, Middle, Last) Romualdas Nemickas		2. SEX Male		3a. TIME OF DEATH 10:34a M		3b. DATE OF DEATH (Month, Day, Yr.) February 15, 1991	
4. SOCIAL SECURITY NUMBER 304-32-9181		5a. AGE—Last Birthday (Years) 79		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) August 10, 1911		7. BIRTHPLACE (City and State or Foreign Country) Lithuania					
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 checked="" 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) Elena Saulyte		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Pipefitter		12b. KIND OF BUSINESS/INDUSTRY Steel	
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Highland		13d. STREET AND NUMBER 8349 Delaware Street	
13e. ZIP CODE 46322		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		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) Unavailable				19. MOTHER'S NAME (First, Middle, Maiden Surname) Unavailable			
20a. INFORMANT'S NAME (Type/Print) Elena Nemickas				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8349 Delaware St, Highland, Indiana 46322		20c. Relationship Wife	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" 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) Feb. 15, 1991 Marquette Funeral Home Chicago, Illinois Feb. 18, 1991 St. Casimir Cemetery Chicago, Illinois		21c. LOCATION—City or Town, State			
22a. EMBALMER'S NAME Larry D. Anthony		22b. EMBALMER'S LICENSE NO. 01001447		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		24b. LICENSE NUMBER (of Licensee) 01001447		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz F.H. 83002916 9445 Calumet Ave, Munster, IN 46321			
26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCARDIAL DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DUE TO (OR AS A CONSEQUENCE OF): HEALTH DEPT. FEB 21, 1991		PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. ESSENTIAL HYPERTENSION		27. WAS DECEDENT PREGNANT OR POSTPARTUM? (Yes or no) No		28. WERE AUTOPSY FINDINGS PERFORMED PRIOR TO COMPLETION OF CAUSE OF DEATH? (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>S. Prasad Tummala MD</i>		29c. MEDICAL LICENSE NO. 11. 36-48047		29d. DATE SIGNED (Month, Day, Year) February 16, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) S. PRASAD TUMMALA, M.D., 6132 S. KEDZIE AVENUE, CHICAGO, ILLINOIS 60629							
31. HEALTH OFFICER'S SIGNATURE <i>S. Prasad Tummala MD</i>						32. DATE FILED (Month, Day, Year) Feb 20, 1991	
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.			



THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.