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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

2008-06-5093  
**Survivorship Affidavit** SEP 17 AM 9:07

MICHAEL A. BROWN  
RECORDER

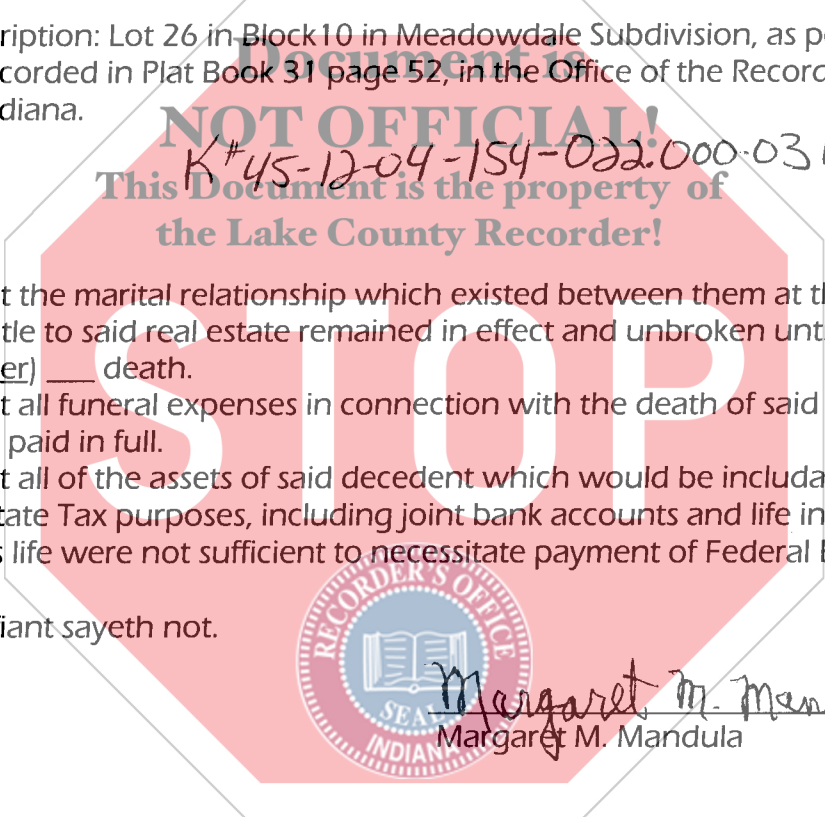
State of Indiana )  
 ) SS:  
County of Lake )

2008 06 50 93 4

Margaret M. Mandula, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse Michael J. Mandula died (without leaving a will) X (leaving a will)      on May 1st 1992,      at Valparaiso, In
2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:  
1421 West 55<sup>th</sup> Ave., Merrillville, In 46410

Legal description: Lot 26 in Block 10 in Meadowdale Subdivision, as per plat thereof, recorded in Plat Book 31 page 52, in the Office of the Recorder of Lake County, Indiana.

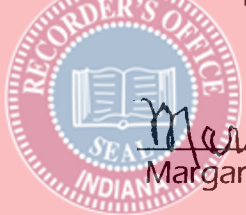


K#45-12-04-154-022.000-03

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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) X (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.

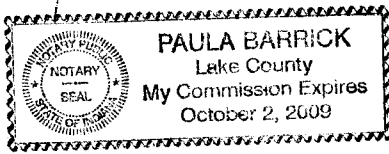
Further affiant sayeth not.



Margaret M. Mandula  
Margaret M. Mandula

Subscribed and sworn to before me, a Notary Public, this 5th day of September, 2008.

Paula Barrick



My Commission expires:  
10/02/09

County of Residence:  
Lake

**FILED**

**SEP 15 2009**

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

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AB

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920085188

**015093**

THIS DOCUMENT NOT  
VALID UNLESS STAMPED  
ON REVERSE SIDE

PORTER COUNTY BOARD OF HEALTH  
MEDICAL CERTIFICATE OF DEATH

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) Mike Mandula		2. SEX Male		3a. TIME OF DEATH 4:20A <sub>M</sub>		3b. DATE OF DEATH (Month, Day, Yr) May 1, 1992							
4. SOCIAL SECURITY NUMBER 314-03-3210		5a. AGE—Last Birthday (Years) 72		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) Sept. 4, 1919		7. BIRTHPLACE (City, and State or Foreign Country) Velka Breznica Czechoslovakia			
8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945		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 type="checkbox"/> Residence									
9b. FACILITY NAME (If not institution, give street and number) Pavillion Health Center						9c. CITY, TOWN, OR LOCATION OF DEATH Valparaiso			9d. COUNTY OF DEATH Porter				
10. MARITAL STATUS Married		11. SURVIVING SPOUSE (If wife, give maiden name) Margaret			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Industrial Engineer			12b. KIND OF BUSINESS/INDUSTRY USX Corp					
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Merrillville			13d. STREET AND NUMBER 1421 W 55th Avenue						
13e. ZIP CODE 46410		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input type="checkbox"/> Yes		13g. ON A FARM? <input type="checkbox"/> No <input 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) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> 4	
18. FATHER'S NAME (First, Middle, Last) John Mandula						19. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Vasko							
20a. INFORMANT'S NAME (Type/Print) Margaret Mandula						20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1421 W 55th Avenue Merrillville, IN				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 4, 1992 Calumet Park Cemetery				21c. LOCATION—City or Town, State Merrillville, IN.					
22a. EMBALMER'S NAME David Semplinski				22b. EMBALMER'S LICENSE NO. FD08600686				23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
24a. SIGNATURE OF FUNERAL DIRECTOR Robert Wiatrolik				24b. LICENSE NUMBER (of Licensee) FD01001293				25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Stilinovich & Wiatrolik 7535 Taft St. Merrillville, IN. PH3004455					
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. <u>Cerebral Vascular Accident</u> 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.  PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. <u>Pneumonia</u>												Approximate Interval Between Onset and Death	
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) 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. 01024990		29d. DATE SIGNED (Month, Day, Year) May 7, 1992			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Swarner 1101 E. Glendale Blvd. Valparaiso, IN. 46383													
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>										32. DATE FILED (Month, Day, Year) May 7, 1992			
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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.									