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STATE OF INDIANA )  
 ) SE.  
COUNTY OF LAKE

2009 079495

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2009 DEC -1 PM 3:59  
MICHAEL A. BROWN  
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Kenneth G. Curosh ("Affiant"), first being duly sworn under oath deposes and says:

1. That the Affiant was born on January 18, 1948 and is the son of Anne M. Curosh and Joseph L. Curosh.
2. That the Affiant resides in Lake County, State of Indiana.
3. That Anne M. Curosh and Joseph L. Curosh ("the Decedent") were married on November 9, 1940 and the marital relationship which existed between Anne M. Curosh and Joseph L. Curosh ("the Decedent") continued unbroken from the date of their marriage until the date of the death of Joseph L. Curosh on November 28, 1970.

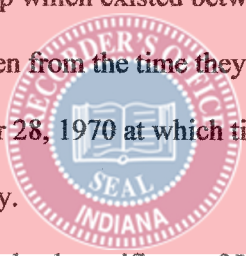
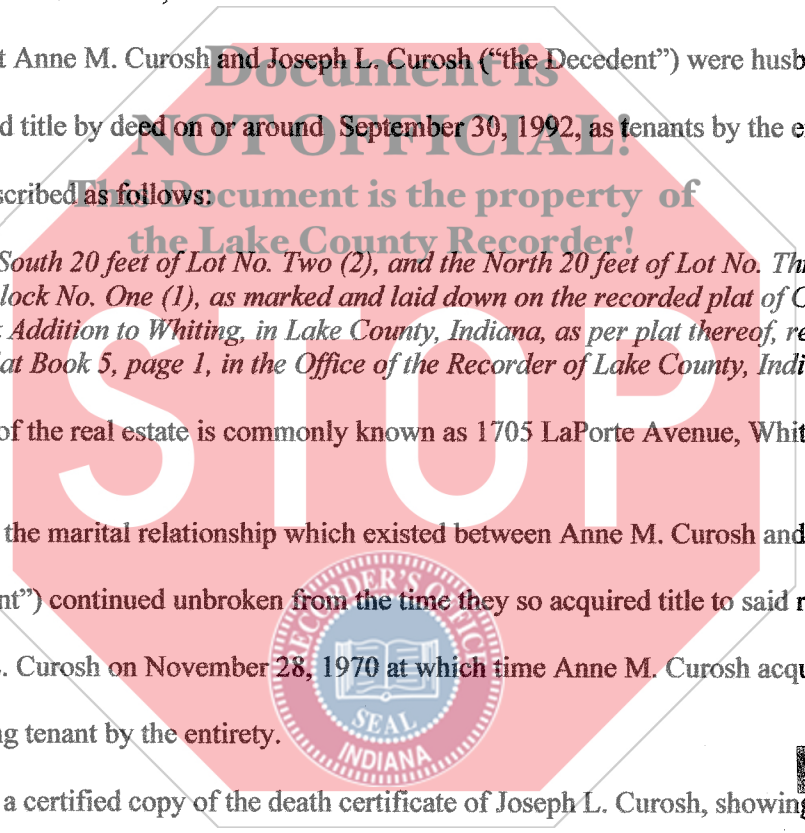
4. That Anne M. Curosh and Joseph L. Curosh ("the Decedent") were husband and wife at the time they acquired title by deed on or around September 30, 1992, as tenants by the entirety, to certain real estate described as follows:

*The South 20 feet of Lot No. Two (2), and the North 20 feet of Lot No. Three (3), in Block No. One (1), as marked and laid down on the recorded plat of Central Park Addition to Whiting, in Lake County, Indiana, as per plat thereof, recorded in Plat Book 5, page 1, in the Office of the Recorder of Lake County, Indiana*

The address of the real estate is commonly known as 1705 LaPorte Avenue, Whiting, Indiana 46394.

5. That the marital relationship which existed between Anne M. Curosh and Joseph L. Curosh ("the Decedent") continued unbroken from the time they so acquired title to said real estate until the death of Joseph L. Curosh on November 28, 1970 at which time Anne M. Curosh acquired title to said real estate as surviving tenant by the entirety.

6. That a certified copy of the death certificate of Joseph L. Curosh, showing his date of death to be November 28, 1970 is attached hereto, made a copy of this affidavit by reference, and identified as Exhibit A.



**FILED**  
DEC 01 2009

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

1800  
CK 3287 021256  
RM



CITY OF EAST CHICAGO, INDIANA  
DEPARTMENT OF HEALTH  
CITY HALL

# Local Record of Death

THIS IS TO CERTIFY,  
That our records show JOSEPH L. CUROSH SR. died

<u>11</u> MONTH	<u>28</u> DAY	<u>1970</u> YEAR	<u>ST. CATHERINE HOSPITAL</u> PLACE	<u>EAST CHICAGO, INDIANA</u> STREET. HOSPITAL
Age at Death <u>60</u> Years	<u>9</u> Months	<u>21</u> Dcys	Sex <u>MALE</u>	Married <u>X</u> Widowed _____
Birth Date <u>2</u> Month	<u>7</u> Day	<u>1910</u> Year	Color <u>WHITE</u>	Single _____ Divorced _____
Primary cause of death given was <u>CARDIAC &amp; RENAL INSUFFICIENCY</u> <u>ARTERIO SCLEROTIC</u> <u>HEART DISEASE</u> <u>CHRONIC NEPROSCLEROSIS</u>				

Signed by C.E. FRANKOWSKI M.D. Physician WHITING, IN Address

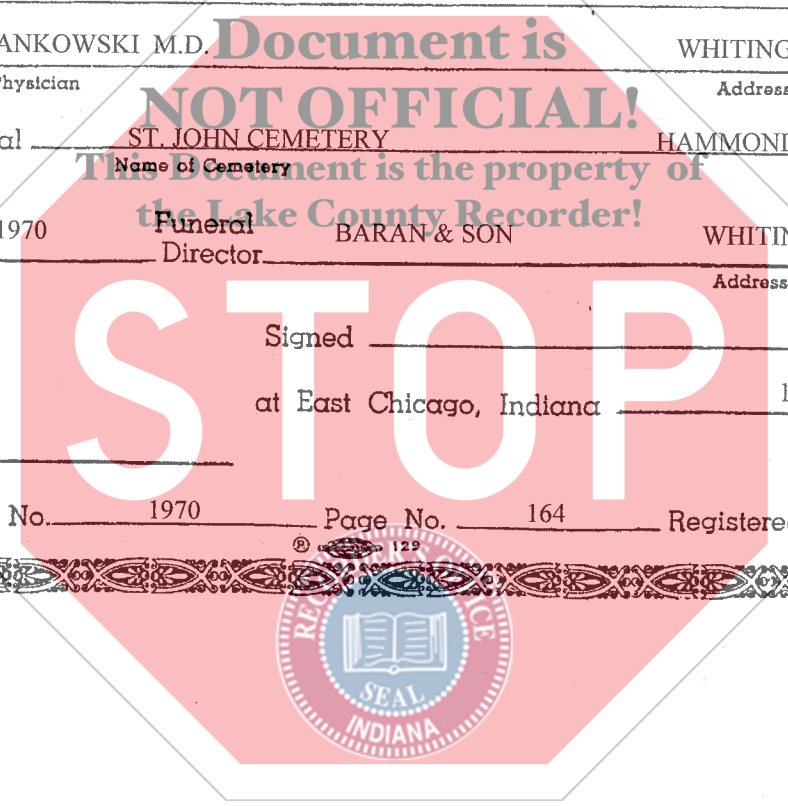
Place of burial or removal ST. JOHN CEMETERY Name of Cemetery HAMMOND, IN

Date of burial 12/1/1970 Funeral Director BARAN & SON WHITING, IN Address

Signed \_\_\_\_\_ Sec'y  
at East Chicago, Indiana 12/1/2009 Date

Filed 12/4/1970

Recorded locally in Book No. 1970 Page No. 164 Registered No. 815



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

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Local No. 131

State No. ....

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Anne M. Curosh			2. SEX Female		3a. TIME OF DEATH 6:49A. M		3b. DATE OF DEATH (Month, Day, Yr) February 22, 2006		
4. *SOCIAL SECURITY NUMBER 312-09-3251		5a. AGE—Last Birthday (Years) 88	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) August 24, 1917		7. BIRTHPLACE (City and State or Foreign Country) Jersey City, New Jersey	
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		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) St. Margaret Mercy Healthcare Center				9c. CITY, TOWN, OR LOCATION OF DEATH Hammond			9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Widowed		11. SURVIVING SPOUSE (If wife, give maiden name) None		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Homemaker			12b. KIND OF BUSINESS/INDUSTRY Own Home		
13a. RESIDENCE—STATE Indiana		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION Whiting			13d. STREET AND NUMBER 1705 LaPorte Avenue		
13e. ZIP CODE 46394		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? 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) <u>12</u> College (1-4 or 5+) _____									
18. FATHER'S NAME (First, Middle, Last) Paul Hamnik					19. MOTHER'S NAME (First, Middle, Maiden Surname) Verona Babjik				
20a. INFORMANT'S NAME (Type/Print) Mr. Kenneth Curosh				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 LaPorte Ave., Whiting, IN 46394				20c. Relationship Son	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <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) February 24, 2006 St. John Cemetery				21c. LOCATION—City or Town, State Hammond, Indiana		
22a. EMBALMER'S NAME Henry J. Blake				22b. EMBALMER'S LICENSE NO. FDE01019406		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>				24b. LICENSE NUMBER (of Licensee) FDE01019456		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Baran & Son, Inc., FDH83007267 1235-119th St., Whiting, IN 46394			
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>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): _____ Approximate Interval Between Onset and Death: <u>Days</u> b. <u>acute myocardial infarction</u> 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.  27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <u>No</u> 28a. WAS AN AUTOPSY PERFORMED? (Yes or no) <u>No</u> 28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <u>N/A</u>									
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. 01034207		29d. DATE SIGNED (Month, Day, Year) Feb 22-06	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29b) (Type/Print) DR. Magsaysay 450 Hohman Ave Hammond In 46320									
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>								32. DATE FILED (Month, Day, Year) February 24, 2006	
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.						