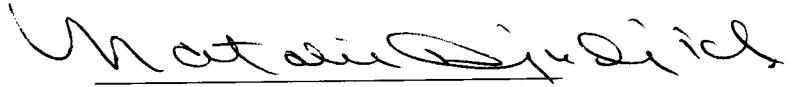
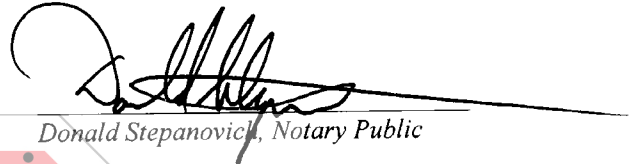




8. I make this affidavit pursuant to Indiana Code Section 29-1-8-3 for the purposes of proving my title in fee to the real estate described in paragraph 4 of this affidavit and my right to the funds in the checking account described in paragraph 7 of this affidavit

  
NATALIE DJUDICH

On the 1st day of May, 2013, Natalie Djudic personally appeared before me, a Notary Public, in and for Lake County, Indiana, and she swore to the truth of the foregoing statements and subscribed to this affidavit in my presence.

  
Donald Stepanovich, Notary Public



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

  
Donald Stepanovich Attorney # 709-45

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

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

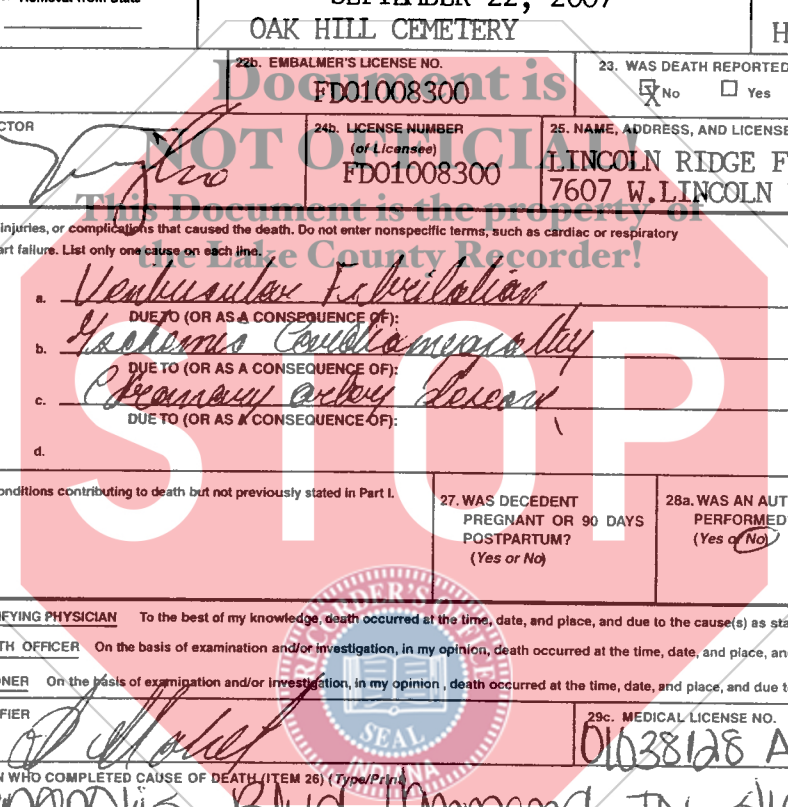
DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>ALEXANDAR ALEKSANDAR DJUDJIC</b>			2. SEX <b>MALE</b>		3a. TIME OF DEATH <b>11:56 PM</b>		3b. DATE OF DEATH (Month, Day, Year) <b>SEPTEMBER 18, 2007</b>					
4. SOCIAL SECURITY NUMBER <b>311-32-9974</b>		5a. AGE—Last Birthday (Years) <b>82</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo, Day, Yr) <b>FEB. 12, 1925</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>SABAC, YUGOSLAVIA</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 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) <b>COMMUNITY HOSPITAL</b>					9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>			9d. COUNTY OF DEATH <b>LAKE</b>				
10. MARITAL STATUS <b>WIDOWED</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>STEEL WORKER</b>				12b. KIND OF BUSINESS/INDUSTRY <b>INLAND STEEL COMPANY</b>				
13a. RESIDENCE—STATE <b>INDIANA</b>		13b. COUNTY <b>LAKE</b>		13c. CITY, TOWN, OR LOCATION <b>EAST CHICAGO</b>			13d. STREET AND NUMBER <b>4009 GRAND BLVD.</b>					
13e. ZIP CODE <b>46312</b>		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</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 +)		
18. FATHER'S NAME (First, Middle, Last) <b>DANILO DJUDJIC</b>					19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KATARINA</b>							
20a. INFORMANT'S NAME (Type/Print) <b>NATALIE DJUDJICH</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>4009 GRAND BLVD. EAST CHICAGO, IN.46312</b>				20c. Relationship <b>DAUGHTER</b>				
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) <b>SEPTEMBER 22, 2007 OAK HILL CEMETERY</b>				21c. LOCATION—City or Town, State <b>HAMMOND, INDIANA</b>					
22a. EMBALMER'S NAME: <b>ELI VUJKO</b>				22b. EMBALMER'S LICENSE NO. <b>FD01008300</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Eli Vujko</i>				24b. LICENSE NUMBER (of Licensee) <b>FD01008300</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN.463</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.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <b>Venousular Thrombosis</b>												
DUE TO (OR AS A CONSEQUENCE OF): b. <b>Systemic Embolism</b>												
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last c. <b>Cerebral artery disease</b>												
DUE TO (OR AS A CONSEQUENCE OF): d.												
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)		28a. WAS AN AUTOPSY PERFORMED? (Yes or No)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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. <b>01038128 A</b>		29d. DATE SIGNED (Month, Day, Year) <b>SEPT. 24, 2007</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>TAM Indigopoyis Blvd Hammond IN 410324</b>												
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>												
32. 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 <b>SEP 24 2007</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.								



**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

State No. ....

Local No. 101

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) VERA DJUDJIC		2 SEX FEMALE		3a TIME OF DEATH 12:10AM		3b DATE OF DEATH (Month Day Yr) APRIL 20, 2001	
4 *SOCIAL SECURITY NUMBER 315-74-5146		5a AGE—Last Birthday (Years) 81		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
6 DATE OF BIRTH (Mo. Day Yr) JUNE 3, 1919		7 BIRTHPLACE (City and State or Foreign Country) YUGOSLAVIA					
8a. WAS DECEDENT A U.S. VETERAN? NO		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? NONE		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. CATHERINE HOSPITAL				9c. CITY, TOWN OR LOCATION OF DEATH EAST CHICAGO		9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) ALEKSANDER DJUDJIC		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 DOMESTIC	
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN OR LOCATION EAST CHICAGO		13d. STREET AND NUMBER 4009 GRAND BLVD.	
13e. ZIP CODE 46312		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" 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) BRANKO POPOVIC				19. MOTHER'S NAME (First, Middle, Maiden Surname) PERZA			
20a. INFORMANT'S NAME (Type/Print) NATALIE DJUDJIC			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 GRAND BLVD. EAST CHICAGO, IND. 46312			20c. Relationship DAUGHTER	
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) APRIL 23, 2001 OAK HILL CEMETERY			21c. LOCATION—City or Town, State HAMMOND, INDIANA	
22a. EMBALMER'S NAME CHARLES WELLS		22b. EMBALMER'S LICENSE NO. FDO1042372		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Eli T...</i>		24b. LICENSE NUMBER (of License) FDO1008300		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 4630			
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>Cardiomyopathy</u> DUE TO (OR AS A CONSEQUENCE OF)					Approximate Interval Between Onset and Death <u>months</u>
		b. <u>End Stage Renal Disease</u> DUE TO (OR AS A CONSEQUENCE OF)					<u>months</u>
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		c. _____ DUE TO (OR AS A CONSEQUENCE OF)					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF)					
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)		28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or 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>Paula Bernick, MD</i>				29c. MEDICAL LICENSE NO. 01045436		29d. DATE SIGNED (Month Day Year) 4/24/01	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) 1534 119th St. Whiting In 46394							
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Raykovich</i>						32. DATE FILED (Month Day Year) 4-24-01	
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.			

