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STATE OF INDIANA)
COUNTY OF LAKE)

SS: 2015 071963

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2015 OCT 23 AM 10:09

AFFIDAVIT OF SURVIVORSHIP MICHAEL B. BROWN
RECORDER

George Timko Jr. ("Affiant"), being duly sworn upon his oath deposes and says:

1. That the Affiant is the son of George Timko Sr. aka George Timko and was born on November 18, 1941
2. That the Affiant resides in Lake County, State of Indiana.
3. That George Timko Sr. aka George Timko ("the Decedent") acquired title on February 18, 1943 along with Emily M. Timko (Wife) as husband and wife, to certain real estate by warranty deed legally described as follows:

Lot 4, in Block No. 1, in Lake Shore Subdivision No. 1, as plat thereof, recorded in Plat Book 26, Page 9, in the Office of the Recorder of Lake County, Indiana, and commonly known as: 2531 New York Avenue, Whiting, Indiana 46394 Parcel Number: 45-03-18-228-003.000-023

4. That the marital relationship which existed between George Timko Sr. aka George Timko ("the Decedent") and Emily M. Timko (Wife) continued unbroken from the time they so acquired title to said real estate until the death of Emily M. Timko on January 15, 1995 at which time George Timko Sr. aka George Timko ("the Decedent") acquired title to said real estate as the sole owner of said real estate.

5. That a copy of the death certificate of Emily M. Timko, (wife), showing she predeceased George Timko Sr. aka George Timko on January 15, 1995, is attached hereto, identified as Exhibit A and made a copy of this affidavit by reference.

AKA Emily Mary Timko

6. That a copy of the death certificate of George Timko Sr. aka George Timko ("the Decedent"), showing his date of death to be February 27, 2007 is attached hereto, identified as Exhibit B and made a copy of this affidavit by reference.

7. That all debts, estate and inheritance taxes, funeral expenses, and expenses of the last illness of Emily M. Timko (Wife) have been fully paid and satisfied.

8. That the undersigned makes this affidavit for the purpose of showing that the said real estate became vested in, George Timko Sr. aka George Timko ("the Decedent") on January 15, 1995 and so that the County Recorder and County Auditor will show on their



FILED

JOHN E. PETALAS
LAKE COUNTY AUDITOR

**FIDELITY NATIONAL
TITLE COMPANY**
92015-2504

FIDELITY-HIGHLAND

920152504

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18-
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mt

records that the above described real estate became vested solely in George Timko Sr. aka George Timko on January 15, 1995.

9. That the said George Timko Sr. aka George Timko, ("the Decedent"), never remarried after the death of his wife, Emily M. Timko on January 15, 1995.

10. That all of the above representations are true.

George Timko Jr.
GEORGE TIMKO JR.

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public, is and for said County and State, personally appeared, George Timko Jr., who being first duly sworn by me upon an oath, states that the facts alleged in the foregoing Affidavit of Survivorship are true.

WITNESS MY HAND AND SEAL this 13th day of October 2015.



[Signature]
NOTARY PUBLIC
Dawn Stanley
PRINTED NAME OF NOTARY PUBLIC

County of Residence: Lake

My Commission Expires: 7/29/18

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

Joseph L. Curosh, Jr.
JOSEPH L. CUROSH, JR.

This instrument prepared by and after recording return to:

Joseph L. Curosh, Jr. – Attorney Number 3473-45
Curosh & Curosh
1532- 119th Street
Whiting, IN 46394

Mail tax bills to: Dean F. Schilling
2531 New York Avenue
Whiting, Indiana 46394

We need to pursue our responsibilities voluntarily and there will be no penalty for sal.

INDIANA STATE DEPARTMENT OF HEALTH

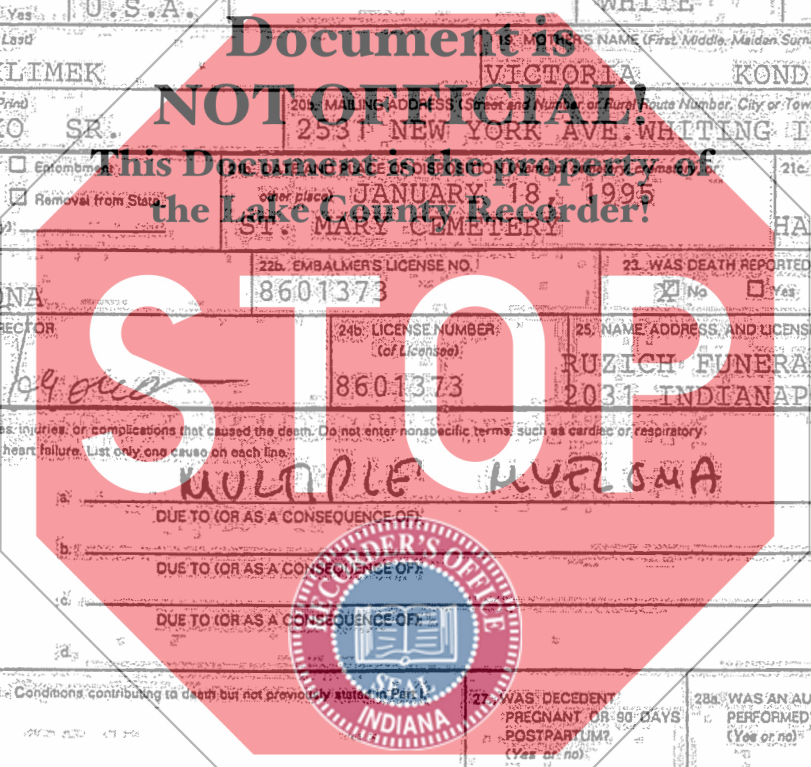
al No: 95-13

CERTIFICATE OF DEATH

State No. _____

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

PE/PRINT IN RMANENT ACK INK	1. DECEASED—NAME (First, Middle, Last) EMILY MARY TIMKO				2. SEX FEMALE	3a. TIME OF DEATH 5:50A.M.	3b. DATE OF DEATH (Month, Day, Year) JANUARY 15, 1995	
	4. *SOCIAL SECURITY NUMBER		5a. AGE—Last Birthday (Years) 77	5b. UNDER 1 YEAR Months: _____ Days: _____	5c. UNDER 1 DAY Hours: _____ Minutes: _____	6. DATE OF BIRTH (Mo., Day, Yr.) MAY 10, 1917		
IDENT	7a. WAS DECEDENT A U.S. VETERAN? NO		7b. YEAR LAST SERVED IN U.S. ARMED FORCES?		9a. PLACE OF DEATH (Check only one. See instructions.) <input checked="" type="checkbox"/> 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 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	
MENTS	10. MARITAL STATUS (Specify) MARRIED		11. SURVIVING SPOUSE (If wife, give maiden name) GEORGE		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 2531 NEW YORK AVE.	
ORMANT	13e. ZIP CODE 46394		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): 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) JOSEPH KLIMEK			
POSITION	19. MOTHER'S NAME (First, Middle, Maiden Surname) VICTORIA KONDZIOLKA				20a. INFORMANT'S NAME (Type/Print) GEORGE TIMKO SR.			
	20b. MAILING ADDRESS (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 2531 NEW YORK AVE. WHITING IN 46394				20c. Relationship: HUSBAND			
USE OF ATH	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. LOCATION—City or Town, State HAMMOND, INDIANA				21c. LOCATION—City or Town, State HAMMOND, INDIANA	
	22a. EMBALMERS NAME JOSE G. CORONA		22b. EMBALMER'S LICENSE NO. 8601373		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
RTIFIER	24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licenses) 8601373		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME RUZICH FUNERAL HOME 46394 2031 INDIANAPOLIS BLVD. WHITING			
	26. PART I: Enter the disease, 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. MULTIPLE MYELOMA		a. DUE TO (OR AS A CONSEQUENCE OF)		Approximate Interval Between Onset and Death			
ALTH FICER	b. DUE TO (OR AS A CONSEQUENCE OF)		c. DUE TO (OR AS A CONSEQUENCE OF)		27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)			
	PART II. Other significant conditions—Conditions contributing to death but not previously stated in Part I.		28a. WAS AN AUTOPSY PERFORMED? (Yes or no)		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)			
RTIFIER	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. 0102748P		29d. DATE SIGNED (Month, Day, Year) 1/16/95	
ALTH FICER	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) DR. GEORGE ASTERIS M.D. 2450 169th STREET HAMMOND INDIANA							
	31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>						32. DATE FILED (Month, Day, Year) 1-17-95	
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. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34e. DESCRIBE HOW INJURY OCCURRED:				
				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

COMPLETE COPY OF DEATH ON FILE WITH
HAMMOND HEALTH DEPARTMENT.

CERTIFICATE OF DEATH

Feb 28 2007
Date Issued
Hammond Health Commissioner

Local No. 19

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

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First, Middle, Last) GEORGE TIMKO, SR.		2. SEX MALE	3. TIME OF DEATH 12:20A	3b. DATE OF DEATH (Month, Day, Year) FEBRUARY 27, 2007	
4. SOCIAL SECURITY NUMBER	5. AGE—Last Birthday (Years) 93	5b. UNDER 1 YEAR Months: Days: 5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) SEPT. 2, 1913	7. BIRTHPLACE (City and State or Foreign Country) COATESVILLE, PA	
8a. WAS DECEDENT A U.S. VETERAN? NO	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	9. 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			
9a. FACILITY NAME (If not institution, give street and number) HAMMOND-WHITING CARE CENTER		9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND	9d. COUNTY OF DEATH LAKE		
10. MARITAL STATUS 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) MACHINIST	12b. KIND OF BUSINESS/INDUSTRY AMOCO OIL COMPANY		
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND (WHITING P.O.)	13d. STREET AND NUMBER 2531 NEW YORK AVENUE		
13e. ZIP CODE 46394	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	
13g. ON A FARM? <input checked="" type="checkbox"/> No; <input type="checkbox"/> Yes	17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+) 12				
18. FATHER'S NAME (First, Middle, Last) JOHN		19. MOTHER'S NAME (First, Middle, Maiden Surname) LABIK			
20a. INFORMANT'S NAME (Type/Print) MR. GEORGE TIMKO, JR.		20b. ADDRESS (Street, Rural Route Number, City or Town, State, Zip Code) 2011 INDIANAPOLIS, 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) MARCH 29, 2007 ST. MARY 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"/> Yes; <input type="checkbox"/> No		
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, 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) CONGESTIVE HEART FAILURE					
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 listed in Part I					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) N/A		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) N/A		
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. 01034865	29d. DATE SIGNED (Month, Day, Year) FEB. 28, 2007		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type/Print) MAHENDRA A. PATEL, M.D. 835-169TH STREET, HAMMOND, INDIANA 46324					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>			32. DATE FILED (Month, Day, Year) February 28, 2007		
33. MANNER OF DEATH <input type="checkbox"/> Natural; <input type="checkbox"/> Pending Investigation; <input type="checkbox"/> Accident; <input type="checkbox"/> Suicide; <input type="checkbox"/> Homicide; <input type="checkbox"/> Could not be Determined		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
34a. PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
35a. DATE PRONOUNCED DEAD (Month, Day, Year)		34e. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

