

2

2008 05 14 19 AM 11:19  
MIDAVIT

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2008 JUL 17 AM 9:02  
MICHAEL A. BROWN  
RECORDER

2017 085152

State Of Indiana }  
                          } SS:  
County of Lake }

Ruth HICKO, being first duly sworn upon oath, deposes and says:  
1. That Scott E. HICKO died on November 23, 2004 at 1:50 AM

2. That Ruth HICKO and Scott E. HICKO were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Office Unit Number 2 in Easton Court Condominium, a Horizontal Property Regime created by a Declaration of Condominium recorded July 11, 1990, as Document No. 111221 and the floor plans thereof recorded July 11, 1990, in Plat Book 69, page 1, and First Amendment thereto recorded June 8, 1992, as Document No. 92036741 and the floor plans thereof recorded June 8, 1992, in Plat Book 72, page 43, in the Office of the Recorder of Lake County, Indiana, and an undivided interest in the common areas and facilities appurtenant thereto.

Property No. 008-08-15-0597-0002  
Property Commonly Known as 310 East 90th Dr, Schererville, IN 46375

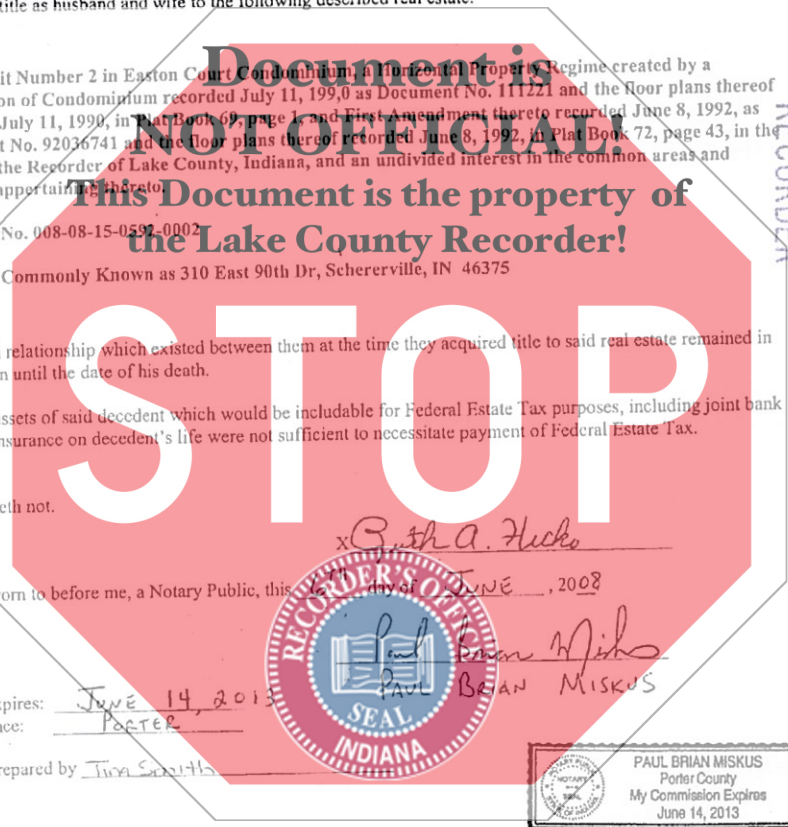
- 3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of his death.
- 4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

Subscribed and sworn to before me, a Notary Public, this 14th day of JUNE, 2008

My Commission expires: June 14, 2013  
County of Residence: Porter

This Instrument prepared by Tim Smith



MICHAEL B. BROWN  
RECORDER

2017 DEC 14 AM 10:19

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

GREEN STAMPS ON DISK

Approved Assessor's Office

By: *[Signature]*

FILED

DEC 12 2017

JOHN E. PETALAS  
LAKE COUNTY AUDITOR

43525

HOLD FOR MERIDIAN TITLE CORP

17-42152

I HEREBY CERTIFY THIS TO BE A TRUE AND EXACT COPY OF THE ORIGINAL.

*[Signature]*

13.00  
1.00  
9039100198  
PB

This document is being re-recorded to add Auditor's stamp

25-MT an

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to assume 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. 2916-04

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

1 DECEASED—NAME (First Middle, Last) SCOTT E. HICKO 2 SEX MALE 3a TIME OF DEATH 1:50 A M 3b DATE OF DEATH (Month, Day, Yr) NOVEMBER 23, 2004

4 SOCIAL SECURITY NUMBER [REDACTED] 5a AGE—Last Birthday (Years) 55 5b UNDER 1 YEAR Month Days 5c UNDER 1 DAY Hours Minutes 6 DATE OF BIRTH (Mo Day Yr) DEC. 11, 1948 7 BIRTHPLACE (City and State or Foreign Country) HAMMOND, INDIANA

8a WAS DECEDENT A U.S. VETERAN? NO 8b YEAR LAST SERVED IN U.S. ARMED FORCES? NONE 8c PLACE OF DEATH (Check only one. See instructions) HOSPITAL  Post-care  ER/Outpatient  DOA  OTHER  Nursing Home  Other (Specify)  Residence

9a FACILITY NAME (If not available, give street and number) SOUTHLAKE METHODIST HOSPITAL 9b CITY, TOWN OR LOCATION OF DEATH MERRILLVILLE 9c COUNTY OF DEATH [REDACTED]

10 MARITAL STATUS MARRIED 11 SURVIVING SPOUSE RUTH A. GRESKOVICH 12a DECEDENT'S USUAL OCCUPATION (Give kind of work or principal occupation or profession. Do not use abbrev.) CERTIFIED PUBLIC ACCOUNTANT 12b KIND OF BUSINESS/INDUSTRY ACCOUNTING

13a RESIDENCE—STATE INDIANA 13b COUNTY LAKE 13c CITY, TOWN OR LOCATION SCHERERVILLE 13d STREET AND NUMBER 331 KING HENRY DR.

13e ZIP CODE 46375 13f INSIDE CITY LIMITS  No  Yes 14 CITIZEN OF WHAT COUNTRY? U.S.A. 15 WAS DECEDENT OF HISPANIC ORIGIN?  No  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) 3+ College (1-4 or 5+) 0

18 FATHER'S NAME (First Middle, Last) EDWARD J. HICKO 19 MOTHER'S NAME (First Middle, Maiden Surname) IMA MARTIN

20a INFORMANT'S NAME (Type/Print) RUTH HICKO 20b MARITAL LICENSE (Specify and include license number, City or Town, State, Zip Code) 331 KING HENRY DR. SCHERERVILLE, IN, 46375 20c Relationship WIFE

21a METHOD OF DISPOSITION  Burial  Cremation  Removal from State  Donation  Other (Specify) 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) NOVEMBER 27, 2004 ST. MICHAEL CEMETERY 21c LOCATION—City or Town, State SCHERERVILLE, INDIANA

22a EMBALMER'S NAME ELI VUJKO 22b EMBALMER'S LICENSE NO. FD01008300 23 WAS DEATH REPORTED TO CORONER?  Yes  No

24a SIGNATURE OF EMBALMER OR OTHER DISPOSER *Eli Vujko* 24b LICENSE NUMBER FD01008300 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME INDEPENDENT FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN, 46307

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) CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF) 4 4 Approximate Interval Between Onset and Death Months

26 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) 28 WAS AN AUTOPSY PERFORMED? (Yes or no) 29 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

29a CERTIFIER (Check only one)  CERTIFYING PHYSICIAN To the best of my knowledge, death occurred on the date, date, and place and due to the cause(s) as stated.  HEALTH OFFICER On the basis of examination and/or investigation, I hereby affirm death occurred on the date, date, and place and due to the cause(s) as stated.  CORONER On the basis of examination and/or investigation, I hereby affirm death occurred on the date, date, and place and due to the cause(s) as stated.

29b SIGNATURE AND TITLE OF CERTIFIER *Barat H Barzu* 29c MEDICAL LICENSE NO. 01030167 29d DATE SIGNED (Month, Day, Year) 12-1-04

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 29b (Type/print) Barat H Barzu 200 S 89th Ave Ste 2A Merrillville, IN 46410

31 HEALTH OFFICER'S SIGNATURE *Barat H Barzu* 31b DATE SIGNED (Month, Day, Year) 11/23/2004

32 MANNER OF DEATH  Natural  Pending Investigation  Accident  Suicide  Could not be Determined  Homicide 32a DATE OF INJURY (Month, Day, Year) 32b TIME OF INJURY 32c INJURY AT WORK? (Yes or no) 32d DESCRIPTION OF INJURY OCCURRED (If applicable) 32e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) 32f LOCATION (Street, road, named, or Rural Highway, Number, City or Town, State)

33a DATE PRONOUNCED DEAD (Month, Day, Year) 33b MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

SDH06-004 State Form 10110 (R5/1-99)

