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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2019 022982

2019 APR 22 AM 10:23

MICHAEL B. BROWN
RECORDER

SURVIVORSHIP AFFIDAVIT

STATE OF Indiana

File No.: FB2320019-00172

COUNTY OF Porter

Case No.:

Comes now Irma Hutnick, who being duly sworn upon his/her oath, deposes and says:

That, Irma Hutnick is the surviving spouse of Joseph Hutnick, deceased, who died domiciled in Lake County, Indiana, on August 6th, 2002.

That Joseph Hutnick and Irma Hutnick acquired title to certain real estate as tenants by the entireties, said real estate being described as follows:

SEE EXHIBIT "A" ATTACHED HERETO AND MADE A PART HEREOF

Affiant states that Joseph Hutnick and Irma Hutnick continued to live and cohabit together as husband and wife continuously from the date they took title to the above described real estate, until the date of Joseph's death.

Affiant states that the total assets of said estate, including the proceeds of life insurance policies and real and personal property, were not sufficient to subject the estate to Federal Estate Tax and that Indiana Inheritance Tax, if any, has been paid.

This affidavit is made for the purpose of maintaining a clear record of title to the above described real estate and to induce the appropriate county authority of Lake County, Indiana, to transfer the above described real estate to .

IN WITNESS WHEREOF, the undersigned have executed this document on April 17th, 2019.

Executed: April 17th, 2019

Irma Hutnick
Signature

Irma Hutnick
Print Name



STATE OF Indiana

COUNTY OF Porter

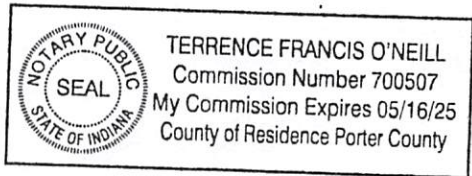
Subscribed and sworn to before me, a Notary Public in and for said county and state, by Irma Hutnick, this 17th day of April, 2019.

Terrence Francis O'Neill

Notary Public Terrence Francis O'Neill

Resident of Porter County

My Commission expires: 05/16/2025



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FILED

APR 22 2019

Page 1
JOHN E. PETALAS
LAKE COUNTY AUDITOR

FIDELITY NATIONAL LC
TITLE COMPANY
FB2320019-00172

CK#1820703947

\$25.00
JB

36
2V
57

* 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. 1335-02

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) JOSEPH HUTNICK, JR.		2 SEX Male	3a TIME OF DEATH 10:15 AM	3b DATE OF DEATH (Month, Day, Year) August 6, 2002	
4 *SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years) 78	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) August 21, 1923	
8a WAS DECEDENT A U.S. VETERAN? YES	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	7 BIRTHPLACE (City and State or Foreign Co) Triadelphia WV			
9a. PLACE OF DEATH (Check only one See instructions)		9b. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center			
10 MARITAL STATUS (Specify) Married		11 SURVIVING SPOUSE (If wife, give maiden name) Irma Duke		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Motor Inspector	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN, OR LOCATION Hobart		12b. KIND OF BUSINESS/INDUSTRY Steel	
13d. ZIP CODE 46342	13e. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	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	
13f. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	17. DECEDENT'S EDUCATION (Specify only highest grade completed)		17. DECEDENT'S EDUCATION (Specify only highest grade completed)		
18 FATHER'S NAME (First, Middle, Last) Joseph Hutnick		19 MOTHER'S NAME (First, Middle, Maiden Surname) Anna Fetchu			
20a. INFORMANT'S NAME (Type/Print) Irma Hutnick		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Center Street, Hobart, IN 46342		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) Aug 10, 2002 Calumet Park Cemetery		21c. LOCATION—City or Town, State Merrillville IN	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FD01006463	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FD01006463	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-041		
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.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) IDENTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE IN THE LAKE COUNTY HEALTH DEPARTMENT					
CONDITIONS, IF ANY, WHICH GAVE RISE TO THE IMMEDIATE CAUSE LISTING THE UNDERLYING CAUSE LAST					
PART II Other significant conditions - Conditions contributing to death but not included by reason of Part I					
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>A. Kales, M.D.</i>			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) Abdul Kawamleh MD 8895 Broadway, Merrillville, IN 46410		29c. MEDICAL LICENSE NO. 01052395A	29d. DATE SIGNED (Month, Day, Year) 8/12/02		
31 HEALTH OFFICER'S SIGNATURE <i>Abdul Kawamleh MD</i>					
32. DATE FILED (Month, Day, Year) August 12, 2002					
33 MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <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
34a. 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			

SURVIVORSHIP AFFIDAVIT
(continued)

Prepared by: Timothy Kuiper
Austgen Kuiper Jasaitis P.C.
130 North Main Street
, Crown Point, IN 46307

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

Judith Lang.

Return to: William M. Huffer and Linda L. Huffer
410 Center St
Hobart, IN 46342

