

AFFIDAVIT OF SURVIVORSHIP

JOSEPH L. NIKSICH and DANIEL A. NIKSICH, upon knowledge and belief, make these statements.

1. That Joseph Louis Niksich Sr. and Mary A. Niksich are the owners of real estate under a duly recorded deed under instrument number Book 1163 Page 38 the office of the Lake County, Indiana Recorder commonly known as 3835 Kentucky Street, Gary, IN. 46409, parcel number \_\_\_\_\_

2. Mary A. Niksich died on July 6, 1994 (a copy of the Owner's death certificate is attached as Exhibit A) Joseph Louis Niksich Sr. died on February 20, 2022 (a copy of the Owner's death certificate is attached as Exhibit B) owning at death an interest in the following described real estate:

The South 10 feet of Lot 8, all of Lot 9, and the North 17 feet of Lot 10, in Block 21, in Great Gary Realty Company's First Addition to Gary, Lake County, Indiana.

3. That by virtue of the death of the parties listed in paragraph #2 above, and by operation of law this property is now owned by Joseph L. Niksich and Daniel A. Niksich, the surviving heirs of Joseph Louis Niksich Sr.

AFFIRMED UNDER PENALTIES FOR PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE.

FILED

Date: 1-5-24

[Signature]  
Joseph Louis Niksich

JAN 17 2024

Date: 1-5-24

[Signature]  
Daniel A. Niksich

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

State of Indiana )  
Starke County )

) SS:



ACKNOWLEDGMENT

I, the undersigned, a Notary Public in and for said County, in said State, hereby certify that JOSEPH L. NIKSICH and DANIEL A. NIKSICH whose names are signed to the foregoing instrument, and who is known to me, acknowledged before me on this day that, being informed of the contents of the instrument, they executed the same voluntarily on the day the same bear's date.

Given under my hand this 01-05-2024

[Signature]  
Notary Public

"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." DN

This instrument prepared by Richard Ballard, Attorney at Law, 52 E. Washington St., Knox, IN 46534

GINA PIMENTEL  
RECORDER  
STATE OF INDIANA  
LAKE COUNTY  
RECORDED AS PRESENTED  
2024-001252  
10:54 AM 2024 Jan 17

CS  
KD

ATTENTION: Disclosure of the SSN we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

Registration No. 51589

# INDIANA STATE DEPARTMENT OF HEALTH

Local No. 1489-94

## CERTIFICATE OF DEATH

State No. \_\_\_\_\_

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1. DECEASED—NAME (First, Middle, Last) <b>Mary A. Niksich</b>				2. SEX <b>Female</b>		3a. TIME OF DEATH <b>12:35 A.M.</b>		3b. DATE OF DEATH (Month, Day, Year) <b>July 6, 1994</b>	
4. SOCIAL SECURITY NUMBER [REDACTED]		5a. AGE—Last Birthday (Years) 57		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes		6. DATE OF BIRTH (Mo., Day, Yr) <b>October 29, 1936</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>		8. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> POA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence							
9a. FACILITY NAME (If not institution, give street and number) <b>Methodist Hospital—Southlake Campus</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Merrillville</b>		9c. COUNTY OF DEATH <b>Lake</b>			
10. MARITAL STATUS (Specify) <b>Married</b>		11. SURVIVING SPOUSE (Last, give maiden name) <b>Joseph L. Niksich</b>		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Bakery</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Wiseway Foods</b>			
13a. RESIDENCE—STATE <b>Indiana</b>		13b. COUNTY <b>Lake</b>		13c. CITY, TOWN OR LOCATION <b>Gary</b>		13d. STREET AND NUMBER <b>3835 Kentucky Street</b>			
13e. ZIP CODE <b>46409</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 DECEASED OF HISPANIC ORIGIN? <input 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. DECEASED'S EDUCATION (Specify only highest grade completed) <b>10</b>		17a. Elementary/Secondary (9-12)		17b. College (1-4 or 5+)					
18. FATHER'S NAME (First, Middle, Last) <b>Mark Nosich</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Theresa N/A</b>					
20a. INFORMANT'S NAME (Type/Print) <b>Joseph L. Niksich</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3835 Kentucky Street, Gary, Indiana 46409</b>				20c. Relationship <b>Husband</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input 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>July 8, 1994 Calumet Park Cemetery</b>				21c. LOCATION—City or Town, State <b>Merrillville, Indiana</b>	
22a. EMBALMER'S NAME <b>Alexis Thanos</b>				22b. EMBALMER'S LICENSE NO. <b>FD08600505</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Alexis Thanos</i>				24b. LICENSE NUMBER (of Licensee) <b>FD08600505</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Geisen Funeral Home, Inc. FH83007762 7905 Broadway, Merrillville, In. 46410</b>			
26. PART I. Enter the disease, injury, or complication that caused the death. Do not enter hospitable terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CAACINOMA OF BREAST WITH METASTASES</b>									
27. IMMEDIATE CAUSE (Final disease or condition resulting in death) <b>CAACINOMA OF BREAST WITH METASTASES</b>									
28. THIS IS A TRUE COPY OF THE RECORD ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT <b>APR 23 2015</b>									
29. PART II. Other significant conditions, Conditions contributing to death but not previously stated in Part I. <b>WAS DECEASED A PRODUCT OF CONCEPTION? LAKE COUNTY HEALTH OFFICER</b> <b>FORMED? (Yes or no) NO</b>									
30. 30a. WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b> 30b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>									
31. 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.									
32. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						33. MEDICAL LICENSE NO. <b>0163016</b>		34. DATE SIGNED (Month, Day, Year) <b>NOT VALID UNLESS</b>	
35. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <b>Dr. Bharat H. Barai, 125 E. 89th Avenue, Merrillville, Indiana 46410</b>									
36. HEALTH OFFICER'S SIGNATURE <i>Alexander D. Williams, M.D.</i>									
37. DATE SIGNED (Month, Day, Year) <b>July 8, 1994</b>									
33. MANNER OF DEATH <input 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. 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.						

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

RAISED SEAL AFFIXED

# NOT AN OFFICIAL DOCUMENT

## INDIANA STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

3666524

Local No 000138

EDR No 000011249745

State No 2022-013389

1. Decedent's Legal Name (First, Middle, Last) <b>Joseph Louis Nikaich Sr</b>				18. Maiden Name (if female)		2. Sex <b>Male</b>		3. Date of Death <b>05-03 PM</b>		4. Date of Death (Month/Day/Year) <b>02/20/2022</b>									
5. Social Security Number <b>88</b>		5b. Under 1 Year Months		5c. Under 1 Month Days		5d. Under 1 Day Hours		5e. Under 1 Hour Minutes		7. Date of Birth (Month/Day/Year) <b>09/18/1933</b>									
9. Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		10. If Death Occurred In A Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department Outpatient <input type="checkbox"/> Dead on Arrival		10a. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility		10b. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility		10c. If Death Occurred Somewhere Other Than A Hospital: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Nursing Home/Long-term Care Facility		6. Birthplace (City and State or Foreign Country) <b>Gary, Indiana</b>									
11. Facility Name (if Not Institution, Give Street and Number) <b>Methodist Hospital Inc-Nikaich Campus</b>																			
12. City or Town, State, and Zip Code <b>Gary, Indiana 46402</b>						13. County of Death <b>Lake</b>			14. Marital Status At Time of Death <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, But Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown										
15. Surviving Spouse's Name				16a. Last Name Before First Marriage				16. Decedent's Usual Occupation <b>Spark Tester</b>		17. Kind of Business/Industry <b>Steel Mill</b>									
18. Residence - State <b>IN</b>			18a. County <b>Lake</b>			18b. City or Town <b>Gary</b>			18c. Apt. No.		18d. Zip Code <b>46409</b>								
19. Decedent's Education <b>High School graduate or GED completed</b>			20. Decedent Of Hispanic Origin Not Spanish/Hispanic/Latino			21. Decedent's Place White			18f. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
22. Parents Name (First, Middle, Last) <b>Andrew Nikaich</b>				23. Parents Name (First, Middle, Last) <b>Helen Nikaich</b>				23a. Parents Last Name Before First Marriage <b>Metanich</b>											
24. Informant's Name <b>Daniel Nikaich</b>				24a. Relationship To Decedent <b>Son</b>				24b. Mailing Address (Street And Number, City, State, Zip Code) <b>3835 Kentucky Street, Gary, IN, 46409</b>											
25a. Method Of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment				25b. Place Of Disposition (Name Of Crematory, Cemetery, Other Place) <b>Heights Crematory</b>				25c. Location - City, Town, and State <b>IL</b>											
26. Was Coroner Contacted? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				27. Name And Complete Address of Funeral Facility <b>Crown Cremation Services 850 N. Madison Street, Crown Point, Indiana, 46307</b>				27a. Funeral Home License Number: <b>FH11300014</b>											
27b. Signature of Indiana Funeral Service Licensee: <b>Kelly Michelle Spruue</b>				27c. License Number Of Licensee: <b>FD21700031</b>				27d. License Number Of Licensee: <b>FD21700031</b>											
28. Part I. Enter The Chain Of Events - Diseases, Injuries, Or Complications - That Directly Caused The Death. Do Not Enter Terminal Events Such As Cardiac Arrest, Respiratory Arrest, Or Ventricular Fibrillation Without Showing The Etiology. Do Not Abbreviate. Enter Only One Cause On A Line. Add Additional Lines If Necessary.																			
Immediate Cause (Final Disease Or Condition Resulting In Death)																			
A. <b>Cardiac Arrest, Respiratory Arrest and Aspiration into airway</b> 4/2013																			
B. <b>Chronic Congestive Heart Failure and Aortic Stenosis</b> 4/2013																			
C. _____																			
D. _____																			
28. Part II. Enter The Underlying Cause (Disease Or Injury That Initiated The Events Resulting In Death) Last																			
Part II. Enter Other Significant Conditions Contributing to Death But Not Resulting In The Underlying Cause Given In Part I																			
31. Chronic Obstructive Pulmonary Disease with Pulmonary hypertension																			
32. Was An Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				33. Was An Autopsy Finding Available To Complete The Cause Of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				34. Manner Of Death: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could Not Be Determined											
35. Date Of Injury (Month/Day/Year)				35a. Time Of Injury				35b. Place Of Injury (E.G., Decedent's Home, Construction Site, Restaurant, Wooded Area)				35c. Injury At Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
36. Location Of Injury - State				36a. City Or Town				36b. Street & Number				36c. Apt. No.				36d. Zip Code			
37. Describe How Injury Occurred																			
40. If Transportation Injury, Specify: <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other Vehicle																			
41. Signature, Of Person Certifying Cause Of Death: <b>Mutena B. Korman</b>				42. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician <input type="checkbox"/> Coroner <input type="checkbox"/> Health Officer				43. License Number <b>01055605A</b>				43. Date Certified <b>02/24/2022</b>							
44. Name, Address And Zip Code Of Person Certifying Cause Of Death: <b>Mutena B. Korman 6111 Harrison Street 380, Merrillville, IN 46410</b>				44. License Number <b>01055605A</b>				44. License Number <b>01055605A</b>				44. Date Certified <b>02/24/2022</b>							
46. Additional Funeral Service Provider:																			
46. Signature of Local Health Officer: <b>Ryland H Walker</b>				46. Signature of Local Health Officer: <b>Ryland H Walker</b>				46. For Registrar Only - Date Filed (Month/Day/Year): <b>03/02/2022</b>				46. For Registrar Only - Date Filed (Month/Day/Year): <b>03/02/2022</b>							
AMENDMENT TO CERTIFICATE OF DEATH (ENTRY OR ORIGINAL)																			

State Form 53395 ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue responsibility. Disclosure is voluntary and there will be no penalty for refusal.

**WARNING:** ORIGINAL DOCUMENT HAS A MULTICOLORED BACKGROUND ON SPECIAL WHITE SECURITY PAPER AND THE GREAT SEAL OF THE STATE OF INDIANA ON BACK THAT TURNS FROM ORANGE TO YELLOW WHEN RUBBED. ORIGINAL DOCUMENT HAS A HIDDEN VOID ON FRONT THAT APPEARS WHEN RUBBED.