6715 MONTANA
HM: 40323

2

93053540 SATISFACTION OF MORTGAGE

This Certifies, *That a certain Mortgage executed by* ....
........John J. Janicki, Jr. and Judith A. Janicki, husband and wife........
.... *to* Casimir Dauksza and Sophie Dauksza....
(deceased - death certificate Doc. # 92013541), husband and wife............
on ....23rd......... *day of* ....December.......... *19* 76..... *calling for $* 12,000.00....... *and recorded*
in Mortgage ~~Record~~ Doc. No. 386310..... xxxxxxx , ...Lake........................ *County,*
State of Indiana, has been fully paid and satisfied, and the same is hereby released.

WITNESS ..my... *hand* ....*and seal*...., *this* ......5th........... *day of* ...August............. *19* 93..

Casimir Dauksza
....Casimir Dauksza........................

AUG 17 8 13 AM '93
STATE OF INDIANA LAKE COUNTY FILED FOR RECORD
RECORDER

State of Indiana, ...Lake.............................*County, SS:*

Before me, the undersigned, a Notary Public in and for said County, this ....5th.........
day of ....August........................ *19* 93, ...
..........Casimir Dauksza...
..........Casimir Dauksza...
acknowledged the execution of the annexed satisfaction of mortgage.

Witness my Hand *and official Seal.*

Donna L. Ladd *Notary Public.*
Donna L. Ladd

My Commission expires ...11/17/95..........

This instrument prepared by: Casimir Dauksza

Resident of ....Lake.................. County

900

Local No. 733

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Sept. 16, 1991 (Date Issued) — Franklin D. Penuela M.D. (Hammond Health Commissioner)

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Sophie Dauksza
2. SEX: Female
3a. TIME OF DEATH: 4:27 a.m.
3b. DATE OF DEATH (Month, Day, Yr): September 14, 1991
4. SOCIAL SECURITY NUMBER: 307-40-6516A
5a. AGE—Last Birthday (Years): 76
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day, Yr): June 11, 1915
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? ----
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9b. FACILITY NAME (If not institution, give street and number): St. Margaret Hospital
9c. CITY, TOWN, OR LOCATION OF DEATH: Hammond
9d. COUNTY OF DEATH: Lake
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): Casimir Dauksza
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Housewife
12b. KIND OF BUSINESS/INDUSTRY: Homemaker
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: Lake
13c. CITY, TOWN, OR LOCATION: Hammond
13d. STREET AND NUMBER: 4827 Magnolia Ave.
13e. ZIP CODE: 46327
13f. INSIDE CITY LIMITS? [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN? [X] 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): 10 years; College (1-4 or 5+): ---

PARENTS

18. FATHER'S NAME (First, Middle, Last): George Stefanski
19. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Fabich

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Casimir Dauksza
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4827 Magnolia Ave. Hammond, Indiana 46327
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): September 17, 1991 Chapel Lawn Memorial Gardens
21c. LOCATION—City or Town, State: Schererville, Indiana
22a. EMBALMER'S NAME: Charles W. Wells
22b. EMBALMER'S LICENSE NO: #1042372
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Mary Solan
24b. LICENSE NUMBER (of Licensee): FD# 1004097
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: SOLAN FUNERAL HOME FH# 83002893 7109 Calumet Ave., Hammond, Ind. 46324

CAUSE OF DEATH

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. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. Pulmonary Arrest.
DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebral Vascular Stroke
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

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 stated in Part I: Diabetes Mellitus

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): ---

CERTIFIER

29a. CERTIFIER (Check only one):
[X] CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated.
[ ] 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.
[ ] 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: W. Loh, M.D.
29c. MEDICAL LICENSE NO.: 31576
29d. DATE SIGNED (Month, Day, Year): Sept. 9/14, 1991
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): W. Loh, M.D. 9108 Columbia Avenue, Munster, Indiana 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Franklin D. Penuela M.D.
32. DATE FILED (Month, Day, Year): Sept. 16, 1991

CORONER USE ONLY

33. MANNER OF DEATH: [ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] 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.