Chicago Title Insurance Company

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SURVIVORSHIP AFFIDAVIT

93078467

STATE OF INDIANA)
) S. S.
COUNTY OF LAKE)

2

On this 10-28-93 (Insert Date) before me personally appeared Stanley B. Zalewski

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;

2. Affiant is Owner (state interest of affiant in the above premises as "owner," "son of owner," etc.);

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Stanley B. and Charlotte I.;

4. Said Charlotte I. Zalewski (fill in name of co-tenant who died)
died on 2-24-87
leaving NO (Insert "a" or "no") will;

5. The legal description of the premises in question is:

LOT 48, BLOCK 2, PLUM CREEK VILLAGE 6TH ADDITION TO THE TOWN OF SCHERERVILLE, AS SHOWN IN PLAT BOOK 61, PAGE 6, IN LAKE COUNTY INDIANA.
Key # 13-399-25

6. To the best of affiant's knowledge there is no Federal or State estate or inheritance tax liability by reason of the death of said decedent;

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

NO

(If answer is "Yes," identify the divorce proceedings:

8. Affiant's relationship to the deceased was husband

Signature: Stanley B. Zalewski
Stanley B. Zalewski
Address: 925 Evergreen Ln
Schererville, In.

Subscribed and sworn to before me by the affiant this 28th Day of October, 1993 (Insert date)

Notary Public
JULIA J. QUISENBERRY
My Commission Expires DECEMBER 16, 1994
RESIDENT OF NEWTON COUNTY, INDIANA

This instrument prepared by STANLEY B. ZALEWSKI

00456

FILED
NOV 19 1993
Auditor Lake County

Nov 23 2 12 PM 93
SARU RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

Local No. 407-89

INDIANA STATE BOARD OF HEALTH
CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): CHARLOTTE I. ZALEWSKI
2. SEX: FEMALE
3. DATE OF DEATH (Mo., Day, Yr.): FEBRUARY 24, 1989
4. SOCIAL SECURITY NUMBER: 335-30-5375
5a. AGE—Last Birthday (Years): 52
5b. UNDER 1 YEAR (Months, Days)
5c. UNDER 1 DAY (Hours, Minutes)
6. DATE OF BIRTH (Month, Day, Year): MARCH 27, 1936
7. BIRTHPLACE (City and State or Foreign Country): EAST CHICAGO, INDIANA
8. YEAR LAST SERVED IN U.S. ARMED FORCES?: NONE
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☒ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): 925 EVERGREEN
9c. CITY, TOWN, OR LOCATION OF DEATH: SCHERERVILLE
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): STANLEY
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): HOME MAKER
12b. KIND OF BUSINESS/INDUSTRY: OWN HOME
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: SCHERERVILLE
13d. STREET AND NUMBER: 925 EVERGREEN
13e. INSIDE CITY LIMITS? (Yes or No): YES
13f. FARM: NO
13g. ZIP CODE: 46375
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes Specify
15. RACE—American Indian, Black, White, etc. (Specify): WHITE
16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

PARENTS

17. FATHER'S NAME (First, Middle, Last): WILLIAM SZIDIK
18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN LIPUS

INFORMANT

19a. INFORMANT'S NAME (Type/Print): STANLEY ZALEWSKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 925 EVERGREEN SCHERERVILLE, INDIANA
19c. Relationship: HUSBAND

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, other place): FEBRUARY 28, 1989 OAKLAND MEMORY
20c. LOCATION—City or Town, State: DALTON, ILLINOIS

21a. SIGNATURE OF FUNERAL DIRECTOR: Thomas G. Burns
21b. LICENSE NUMBER (of Licensee): 1045184
22. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: BURNS-KISH FUNERAL HOMES MUNSTER, INDIANA 3002819

PRONOUNCING PHYSICIAN ONLY

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title
23b. LICENSE NUMBER
23c. DATE SIGNED (Month, Day, Year)
24. TIME OF DEATH
25. DATE PRONOUNCED DEAD (Month, Day, Year)
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No): NO

SEE INSTRUCTIONS

27. PART I. Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, 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): a. Increased intracranial pressure
DUE TO (OR AS A CONSEQUENCE OF): b. Malignant Brain Tumor
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT.

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: MAR 1989
28a. WAS AN AUTOPSY PERFORMED? (Yes or No): NO
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No)

SEE INSTRUCTIONS

CERTIFIER

(Check only one)
☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying cause of death)
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER ☐ CORONER ☐ 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) and manner as stated.

LAKE COUNTY HEALTH COMMISSIONER

29b. SIGNATURE AND TITLE OF CERTIFIER
29a. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): STEVEN M. BAYER M.D. 706 RIDGE ROAD MUNSTER, INDIANA

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE
32. DATE FILED (Month, Day, Year): March 2, 1989

CORONER OR MEDICAL EXAMINER 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)

Copy