ESTATE AFFIDAVIT

Re: BA-11221

Address: 1471 Ohio

Whiting, IN 46394

93086920

Legal Description:

LOT 35, BLOCK 4, STANDARD ADDITION INTHE CITY OF WHITING, AS SHOWN IN PLAT BOOK 6, PAGE 29, IN LAKE COUNTY, INDIANA.

29-03-35

RETURN TO:
FIRST AMERICAN TITLE INS. CO
5285 COMMERCE DR., SUITE 1
CROWN POINT, IN 46307

Patricia A. Kantowski, Affiant, states that:

1. RONALD E. KANTOWSICE, deceased, died on the 12TH of OCTOBER, 1993;

2. Affiant is: ✓ the surviving spouse of the deceased;
— the Personal Representative/Executor-trix of the estate of the deceased;

3. The deceased died: — leaving a will which has been probated;
— leaving a will which has not been probated;
✓ leaving no will;

4. The deceased and Affiant were married on the 14TH day of APRIL, 1956; and were never divorced. (This item applies only to the surviving spouse.)

5. ✓ All expenses of the last illness and funeral of the deceased have been paid;

6. ✓ All State Inheritance Taxes and Federal Estate Taxes attributable to the deceased and his/her estate have been paid;

7. ✓ There are no claims against the estate of the decendent.

FILED
DEC 22 12:03 PM '93
SAMUEL OLIVER ROTH
RECORDER
DEC 21 1993
Jack N. Anton
AUDITOR LAKE COUNTY

STATE OF INDIANA/S.S.NO.
LAKE COUNTY
FILED FOR RECORD

This Affidavit is made to induce First American Title Insurance Company to issue a policy of title insurance on the above-described real estate.

12-10-93
Date

Patricia A. Kantowski
Signature of Affiant

PATRICIA A. KANTOWSKI
Printed Name of Affiant

State of Indiana, County of Lake

Subscribed and sworn to before me, this 10th day of December, 1993.

Corina Uscel Ramos
Printed Name of Notary

Signature of Notary

My Commission expires: 5-16-97

My County of Residence is: Lake

Prepared By:

800
0-978

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

Oct. 14, 1993 — Hammond Health Commissioner

Local No. 851

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

St — Date Issued

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-13-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1 DECEASED—NAME (First Middle Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month Day Yr)
Ronald E. Kantowski	Male	8:15 a.m.	October 12, 1993

4 SOCIAL SECURITY NUMBER	5a AGE—Last Birthday (Years)	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo. Day Yr)	7 BIRTHPLACE (City and State or Foreign Country)
357-26-9863	58			JAN. 17, 1935	CALUMET CITY, IL

8a WAS DECEDENT A U.S. VETERAN?	8b YEAR LAST SERVED IN U.S. ARMED FORCES?	9a PLACE OF DEATH (Check only one. See instructions)
NO	N/A	HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA — OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence

9b FACILITY NAME (If not institution, give street and number)	9c CITY, TOWN OR LOCATION OF DEATH	9d COUNTY OF DEATH
ST. MARGARET MERCY HEALTHCARE CNTR	HAMMOND	LAKE

10 MARITAL STATUS (Specify)	11 SURVIVING SPOUSE (If wife, give maiden name)	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b KIND OF BUSINESS/INDUSTRY
MARRIED	PATRICIA DRANGMEISTER	PIPEFITTER	LTV STEEL CO.

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	WHITING	1471 OHIO AVENUE

13e ZIP CODE	13f INSIDE CITY LIMITS	13g ON A FARM?	14 CITIZEN OF (WHAT COUNTRY)	15 WAS DECEDENT OF HISPANIC ORIGIN? (If yes specify Cuban, Mexican, Puerto Rican, etc)	16 RACE—American Indian, Black, White, etc (Specify)	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+)
46394	[ ] No [X] Yes	[X] No [ ] Yes	U.S.A.	[X] No [ ] Yes	WHITE	12	

PARENTS

18 FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
STANLEY KANTOWSKI	ELIZABETH MATONVICH

INFORMANT

20a INFORMANT'S NAME (Type/Print)	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c Relationship
MRS. PATRICIA KANTOWSKI	1471 OHIO AVE., WHITING, IN 46394	WIFE

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
[X] Burial [ ] Cremation [ ] Entombment [ ] Removal from State [ ] Donation [ ] Other (Specify)	OCTOBER 14, 1993 ST. JOSEPH CEMETERY	DYER, INDIANA

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO	23 WAS DEATH REPORTED TO CORONER?
MARTIN A. DYBEL	FDE01019456	[X] No [ ] Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
M. A. Dybel	FDE01019456	BARAN & SON, INC., FDH83007267 1235-119TH ST., WHITING, IN 46394

CAUSE OF DEATH

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.

		Approximate Interval Between Onset and Death
a. IMMEDIATE CAUSE (Final disease or condition resulting in death)	CEREBRO-VASCULAR ACCIDENT	
b. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last — DUE TO (OR AS A CONSEQUENCE OF)	RESPIRATORY FAILURE	
c. DUE TO (OR AS A CONSEQUENCE OF)		
d.		

FILED

DEC 21 1993

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)
N/A	NO	N/A

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	29c MEDICAL LICENSE NO	29d DATE SIGNED (Month, Day, Year)
N. Sardesai M.D.	01029305	10/13/93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Nitin S. Sardesai, M.D., 9305 Calumet Ave., Munster, In., 46321 — OCT. 13, 1993

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Franklin D. Pennello M.D.	October 14, 1993

33 MANNER OF DEATH	34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
[ ] Natural [ ] Pending Investigation [ ] Accident [ ] Suicide [ ] Could not be Determined [ ] Homicide				

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
	0979