

STATE OF INDIANA )  
 ) SS:  
COUNTY OF LAKE )

94021249

SURVIVORSHIP AFFIDAVIT

On this 28 day of February 1994 before me personal appeared Josephine Walczak 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 mother and surviving joint tenant:
3. Said premises were formerly owned as joint tenants or as tenants by the entireties by Josephine Walczak and Maryann Sus;
4. Said Maryann Sus died on February 14, 1991 leaving NO will;
5. The legal description of the premises in question is:

Part of the Southwest quarter of Section 20, Township 36 North, Range 9 West of the Second Principal Meridian, Commencing at a point in the center of the Ridge Road, which is North 79 degrees 12' West 571.13 feet from the East line of said 160 acre tract, and running thence South parallel with said East line 664.02 feet, thence West 80.89 feet, thence North 0 degrees 7' West 679.73 feet to the center line of said Road, thence South 79 degrees 12' East on said line, 83.85 feet to the place of beginning, containing 1.259 acres, more or less, in the Town of Munster, Lake County, Indiana.

Tax Key No. 28-9-8

Commonly known as 1848 Ridge Road, Munster, Indiana 46321

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? Not Entireties property; Affiant and decedent held as Joint Tenants with rights of Survivorship.

8. Affiant's relationship to the deceased was Mother.

**FILED**

MAR 16 1994

Signature: Josephine Walczak

*Josephine Walczak*  
Josephine Walczak

Address: 1848 Ridge Road

Munster, Indiana 46321

Subscribed and sworn to before me by the affiant this 28 day of February, 1994.

Notary Public Kenneth A. Manning

My Commission Expires: 12-12-94

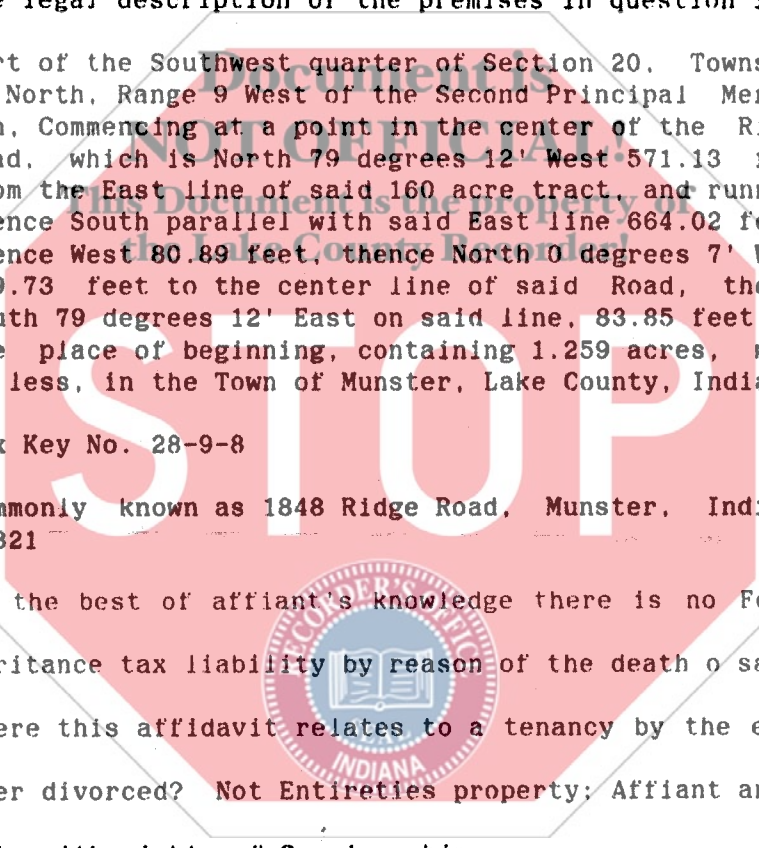
Resident of LAKE County

This instrument prepared by: Kenneth A. Manning, Attorney at Law **00928**  
200 Monticello Drive, Dyer, IN 46311  
Attorney No. 9015-45 (219) 865-8376

STATE RECORDER

MAR 22 8 59 AM '94

STATE OF INDIANA  
LAKE COUNTY  
FILED & RECORDED



800

\*ATTENTION STATE: Disclosure of the SS# we need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

Local No. C.412-94

CERTIFICATE OF DEATH

State No. ....

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

TYPE/PRINT IN PERMANENT BLACK INK

|   |   |  |                                 |  |   |   |
|---|---|--|---------------------------------|--|---|---|
| 1 DECEASED—NAME (First, Middle, Last)<br><b>Maryann Sus</b> |   |  |                                 | 2 SEX<br><b>Female</b>                               | 3a TIME OF DEATH<br><b>3:46 P M</b>   | 3b DATE OF DEATH (Month, Day, Yr)<br><b>February 14, 1994</b> |
| 4 *SOCIAL SECURITY NUMBER<br><b>308-44-3355</b>             | 5a AGE—Last Birthday (Years)<br><b>51</b>               | 5b UNDER 1 YEAR<br>Months Days   | 5c UNDER 1 DAY<br>Hours Minutes | 6 DATE OF BIRTH (Mo, Day, Yr)<br><b>May 21, 1942</b> | 7. BIRTHPLACE (City and State or Foreign Country)<br><b>East Chicago, Indiana</b> |   |
| 8a WAS DECEDENT A U.S. VETERAN?<br><b>NO</b>                | 8b YEAR LAST SERVED IN U.S. ARMED FORCES?<br><b>N/A</b> | 9a PLACE OF DEATH (Check only one. See instructions)<br>HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence |                                 |  |   |   |

DECEDENT

|  |   |   |  |
|--|---|---|--|
| 9b FACILITY NAME (If not institution, give street and number)<br><b>3337 Lincoln St.</b> |   | 9c CITY, TOWN OR LOCATION OF DEATH<br><b>Highland</b>   | 9d COUNTY OF DEATH<br><b>lake</b>                |
| 10 MARITAL STATUS (Specify)<br><b>N. Married</b>   | 11 SURVIVING SPOUSE (If wife, give maiden name)<br><b>N/A</b> | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br><b>Head Librarian</b> | 12b KIND OF BUSINESS/INDUSTRY<br><b>Library</b>  |
| 13a RESIDENCE—STATE<br><b>Indiana</b>  | 13b COUNTY<br><b>Lake</b>                                     | 13c CITY, TOWN, OR LOCATION<br><b>Highland</b>  | 13d STREET AND NUMBER<br><b>3337 Lincoln st.</b> |

PARENTS

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 13e ZIP CODE<br><b>46322</b>                                   | 13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.) | 16 RACE—American Indian, Black, White, etc. (Specify)<br><b>White</b> | 17 DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary; Secondary (10 12); College (1-4 or 5+)<br><b>5+</b> |
| 18 FATHER'S NAME (First, Middle, Last)<br><b>Peter Leo Sus</b> |  |  | 19 MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Josephine Boilek</b>   |   |   |

INFORMANT

|  |  |   |                                   |
|--|--|---|-----------------------------------|
| 20a INFORMANT'S NAME (Type, Print)<br><b>Josephine Walczak</b> |  | 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3337 Lincoln St. Highland, Indiana</b> | 20c Relationship<br><b>Mother</b> |
|--|--|---|-----------------------------------|

DISPOSITION

|  |  |   |
|--|--|---|
| 21a METHOD OF DISPOSITION <input checked="" 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)<br><b>February 17, 1994<br/>Holy Cross Cemetery</b> | 21c LOCATION—City or Town, State<br><b>Calumet City, Illinois</b> |
|--|--|---|

CAUSE OF DEATH

|   |  |   |
|---|--|---|
| 22a EMBALMER'S NAME<br><b>Ronald A. Reed</b>            | 22b EMBALMER'S LICENSE NO.<br><b>FDO 1001081</b>       | 23 WAS DEATH REPORTED TO CORONER?<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                            |
| 24a SIGNATURE OF FUNERAL DIRECTOR<br><i>[Signature]</i> | 24b LICENSE NUMBER (of Licensee)<br><b>FDO 1014511</b> | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME<br><b>Kuiper Funeral Home 9039 Kleinman Rd. Highland, Indiana FDH 300-7500</b> |

PT W2 S. 20 T. 36 R. 9  
1.259AC  
Key # 28-9-8  
unit # 18

|   |  |
|---|--|
| 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.<br><b>Asphyxia due to hanging</b> | Approximate Interval Between Onset and Death<br><b>Unknown</b> |
| IMMEDIATE CAUSE (Final disease or condition resulting in death)<br><b>Asphyxia due to hanging</b>   | <b>FILED</b>   |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last   | <b>MAR 16 1994</b>   |

CERTIFIER

|  |  |  |
|--|--|--|
| 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)<br><b>No</b>     | 28a WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)<br><b>Yes</b> |
| 29a CERTIFIER (Check only one)<br><b>Deputy</b> <input checked="" type="checkbox"/> <b>CORONER</b>   | 29b SIGNATURE AND TITLE OF CERTIFIER<br><i>Kathy Philpot, Deputy Coroner</i> |  |
| <input 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 | 29c MEDICAL LICENSE NO.<br><b>N/A</b>  | 29d DATE SIGNED (Month, Day, Year)<br><b>February 16, 1994</b>                                       |

HEALTH OFFICER

|  |   |  |
|--|---|--|
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type, Print)<br><b>Kathy Philpot, Deputy Coroner, 2183 North Main Street, Crown Point, Indiana 46307</b> | 31 HEALTH OFFICER'S SIGNATURE<br><i>Alexander D. Williams, M.D.</i> | 32 DATE FILED (Month, Day, Year)<br><b>February 16, 1994</b> |
|--|---|--|

|  |  |   |  |  |
|--|--|---|--|--|
| 33 MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined | 34a DATE OF INJURY (Month, Day, Year)<br><b>Feb 14, 1994</b> | 34b TIME OF INJURY<br><b>Unknown</b>  | 34c INJURY AT WORK? (Yes or no)<br><b>No</b> | 34d DESCRIBE HOW INJURY OCCURRED<br><b>Hanging</b> |
| 34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)<br><b>Home</b>  |  | 34f LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>3337 Lincoln Street Highland, Indiana</b> |  |  |

|   |   |              |
|---|---|--------------|
| 34g DATE PRONOUNCED DEAD (Month, Day, Year)<br><b>February 14, 1994</b> | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.<br><b>No</b> | <b>00929</b> |
|---|---|--------------|