



Chicago Title Insurance Company

94024193 SURVIVORSHIP AFFIDAVIT

Liberty Sav. 4044
1901 S. Dupont St.
Whiting, Ind

STATE OF TEXAS }
COUNTY OF HARRIS } S. S.

On this 19th day of March, 1994 before me personally appeared Lorraine M. Shimala,
(insert date)
by James A. Shimala, her attorney-in-fact

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 F. Shimala and Lorraine M. Shimala;

4. Said Stanley F. Shimala died on January 19, 1991

leaving a will; (insert "a" or "no": if will left, attach a copy)

- 5. The legal description of the premises in question is: Lot 3, and the North 10 feet of Lot 4, Block 7, Central Park Addition to Whiting, as shown in plat book 5 page 1 in Lake County, Indiana.

28-29-39-3

- 6. To the best of affiant's knowledge there is no Federal or State estate or inheritance 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:)

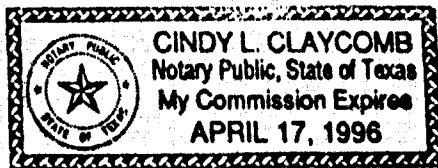
- 8. Affiant's relationship to the deceased was Wife

Signature: Lorraine M. Shimala
LORRAINE M. SHIMALA
by James A. Shimala, her attorney-in-fact
Address:

Subscribed and sworn to before me by the affiant

this 19th day of March, 1994 (insert date)

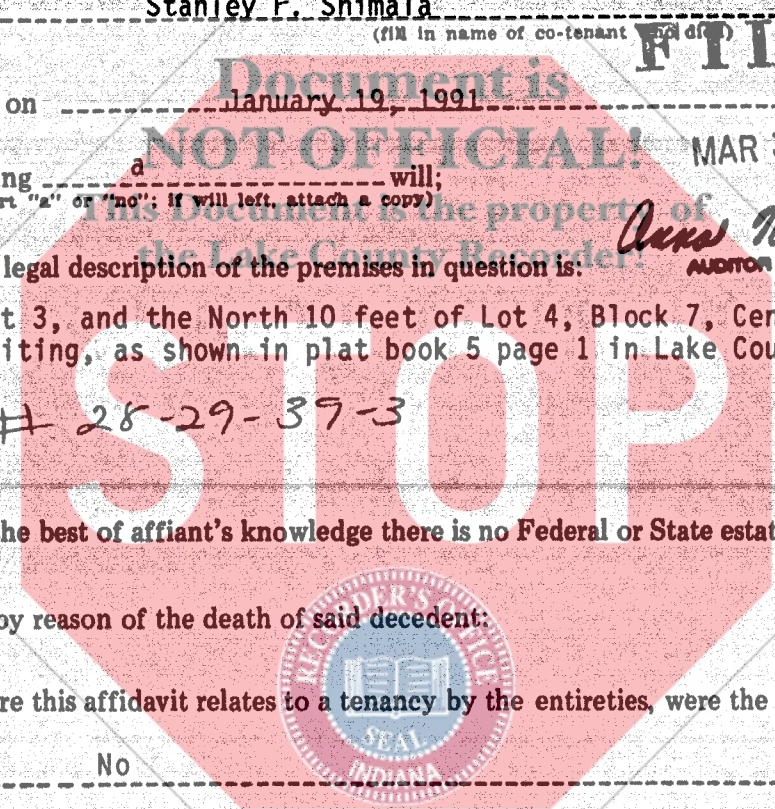
Cindy L. Claycomb
Notary Public



My Commission Expires 4-17-96

This instrument prepared by James A. Shimala, attorney-in-fact for Lorraine M. Shimala

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Chicago Title Insurance Company

STATE OF INDIANA, S.S. IND.
LAKE COUNTY
FILED FOR RECORD
MAR 30 1 44 PM '94
SANDY RECORDER

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 18

State No. _____

TYPE/PRINT
IN
PERMANENT
BLACK INK

1. DECEASED—NAME (First Middle Last) STANLEY F. SHIMALA		2. SEX MALE	3a. TIME OF DEATH 5:59P.	3b. DATE OF DEATH (Month Day Year) January 19, 1991
4. SOCIAL SECURITY NUMBER 314-14-4474	5a. AGE—Last Birthday (Years) 68	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo. Day Year) April 4, 1922
7. BIRTHPLACE (City and State or Foreign Country) Hammond, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1945	
9a. PLACE OF DEATH (Check only one See instructions) <input type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		<input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) St. Catherine Hospital		9c. CITY TOWN OR LOCATION OF DEATH East Chicago	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Lorraine Kaminsky	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Laboratory Technician	12b. KIND OF BUSINESS/INDUSTRY Amoco Oil Company	
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Whiting	13d. STREET AND NUMBER 1807 Central Avenue	
13e. ZIP CODE 46394	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> 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) College (1-4 or 5) 1		18. FATHER'S NAME (First Middle Last) Thomas Shimala		
19. MOTHER'S NAME (First Middle Maiden Surname) Agnes Gmerek		20a. INFORMANT'S NAME (Type/Print) Mrs. Lorraine Shimala		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Central, Whiting, IN 46394		20c. Relationship Wife		
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) January 23, 1991 Holy Cross Cemetery		21c. LOCATION—City or Town, State Calumet City, Ill
22a. EMBALMER'S NAME Martin A. Dybel		22b. EMBALMER'S LICENSE NO. FDE01019456	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Martin A. Dybel</i>		24b. LICENSE NUMBER (of Licensee) FDE01019456	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Baran & Son, Inc., FDM83007267 1235-119th, Whiting, IN 46394	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) hypertensive cardiac vascular dx DUE TO (OR AS A CONSEQUENCE OF) _____ DUE TO (OR AS A CONSEQUENCE OF) _____		Approximate Interval Between Onset and Death 3 yrs 1 yr		
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) 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) ---
29a. 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.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William V. Garvin D.O.</i>		
29c. MEDICAL LICENSE NO. 02000216		29d. DATE SIGNED (Month Day, Year) Jan. 21, 1991		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) William V. Garvin, D.O., 1010-119th Street, Whiting, Indiana 46394				
31. HEALTH OFFICER'S SIGNATURE <i>Dr. Tom Rasporovich</i>				32. DATE FILED (Month Day, Year) 1-21-91
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. 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		

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

CORONER USE ONLY

Checked to file Insurance Company