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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

95 JUN -1 AM 9:30

RECORDER

FILED

JUN 1 1995

SAM ORLICH
AUDITOR LAKE COUNTY

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT OF JEAN S. JAROSZ

Jean S. Jarosz, being first duly sworn upon oath, deposes and says:

1. That I was the wife of Stanley M. Jarosz who died on December 4, 1989.

2. That a certified copy of the Death Certificate of Stanley M. Jarosz is attached to this Affidavit.

3. That at the time of Stanley M. Jarosz's death, title to the following described real estate located in Lake County, Indiana:

Lots 15 to 18, both inclusive, in Block 7 in F.D. Barnes' Second Gary Addition, in the City of Hobart, as per plat thereof, recorded in Plat Book 13, page 2, in the Office of the Recorder of Lake County, Indiana.

was held in the following names: Stanley M. Jarosz and Jean S. Jarosz, husband and wife.

4. That Stanley M. Jarosz and I acquired title to said real estate as husband and wife by a deed dated 11-2-62 and recorded 11-2-62 in the Office of the Recorder of Lake County, Indiana in Deed Book _____, page _____. #44156

5. That Stanley M. Jarosz and I remained husband and wife continuously from the date we acquired title to said real estate until the date of his death on December 4, 1989.

6. That any Indiana inheritance tax or federal estate tax due or payable as a result of the death of Stanley M. Jarosz has been or will be paid.

7. That I affirm under the penalties for perjury that the above statements are true and that I am over the age of 18 years and am competent to make this Affidavit.

Jean S. Jarosz
Jean S. Jarosz

000019

10.00

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for said County and State, this 16th day of May, 1995

David C. Lutz
Notary Public

My Commission Expires:

8/16/97

DAVID C. LUTZ
Printed Name

My County of Residence is:

Lake County, Indiana

This document was prepared by: Mary P. Bottum, 328 N. Michigan St., South Bend, IN 46601

TRUSTS · ESTATE AND TAX PLANNING

DAVID C. LUTZ
Executive Business Services LTD

Senior Education Center

1-800-851-9332
1-219-738-8233 (Display Pager) 9
1-219-663-1971 (FAX)

927 MAXWELL COURT
CROWN POINT, IN 46307-8009

Local No. 4731-89

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): STANLEY M. JAROSZ
2. SEX: MALE
3a. TIME OF DEATH: 12:05P M
3b. DATE OF DEATH (Month, Day, Yr.): DECEMBER 4, 1989
4. SOCIAL SECURITY NUMBER: 311-10-6054
5a. AGE—Last Birthday (Years): 70
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo., Day, Yr.): JUNE 10, 1919
7. BIRTHPLACE (City and State or Foreign Country): FAYETTE CO., PA
8a. WAS DECEDENT A U.S. VETERAN?: YES
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: WWII 1945
9. PLACE OF DEATH (Check only one. See Instructions): HOSPITAL [X] Inpatient [ ] ER/Outpatient [ ] DOA; OTHER [ ] Nursing Home [ ] Other (Specify) [ ] Residence
9a. FACILITY NAME (If not institution, give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN, OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): JEAN S. PRENDERGAST
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): CABLE ELECTRICIAN
12b. KIND OF BUSINESS/INDUSTRY: UTILITY N.I.P.S.C.O.
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: HOBART
13d. STREET AND NUMBER: 3840 BARNES ST.
13e. ZIP CODE: 46342
13f. INSIDE CITY LIMITS? [ ] No [X] Yes
13g. ON A FARM? [X] No [ ] Yes
14. CITIZEN OF WHAT COUNTRY?: USA
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; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First, Middle, Last): ANDREW JAROSZ (DEC)
19. MOTHER'S NAME (First, Middle, Maiden Surname): MARY SIENIAWSKA (DEC)

INFORMANT

20a. INFORMANT'S NAME (Type/Print): JEAN S. JAROSZ
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3840 BARNES ST. HOBART, IN 46342
20c. Relationship: SPOUSE

DISPOSITION

21a. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from State [ ] Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): DECEMBER 17, 1989 CALVARY CEMETERY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES W. GHOLSTON
22b. EMBALMER'S LICENSE NO.: FD01004194
23. WAS DEATH REPORTED TO CORONER? [X] No [ ] Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Gerald Rees
24b. LICENSE NUMBER (of Licensee): FD01041083
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: REES FUNERAL HOME, INC. FDH3003069 600W. OLD RIDGE RD, HOBART, IN 46342

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

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. (Interval between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Obstructive Lung Disease

d.

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I: Acute Renal Failure - Uremia and Shutdown.

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): 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: X Jerold N. Chip
29c. MEDICAL LICENSE NO.: 01019735
29d. DATE SIGNED (Month, Day, Year): 12-5-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Jerold N. Chip, M.D. 7863 Broadway Merrillville, Indiana 46410

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Jerold N. Chip Carol A. Johnson
32. DATE FILED (Month, Day, Year): Dec 5, 1989

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.: