

97 APR 11 AM 10:44

MORRIS W. CARTER  
RECORDER

STATE OF INDIANA )  
COUNTY OF LAKE ) SS

97022184

AFFIDAVIT OF SURVIVORSHIP

Comes now, Helen J. Fesko, as the surviving spouse of the Estate of Jack Fesko, Deceased, being duly sworn upon her oath, and states as follows:

1. That the undersigned, Helen J. Fesko is the spouse of Jack Fesko, and that the undersigned made this affidavit based upon personal knowledge of the facts contained herein.

2. That Jack Fesko, at that the time of his death, being the 6th day of January, 1995, was the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described in Exhibit "A".

3. That Jack Fesko and Helen J. Fesko were husband and wife at the time they acquired title, as tenants by the entireties, to said above-described real estate.

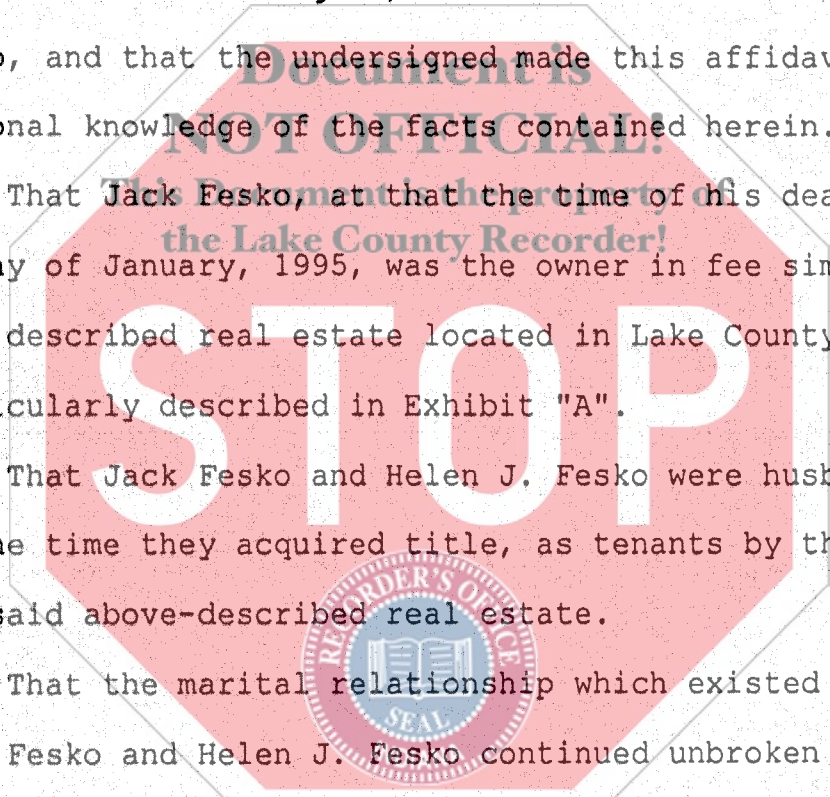
4. That the marital relationship which existed between said Jack Fesko and Helen J. Fesko continued unbroken from the time they so acquired title to said above-described real estate until the death of Jack Fesko on the 6th day of January, 1995.

5. That the gross value of the estate of the decedent, Jack Fesko, as determined for the purpose of federal estate taxes, was less than the value required for the filing of a federal estate tax return; and that as a consequence thereof, said decedent's estate was not subject to federal estate tax.

**FILED**

APR 11 1997

SAM ORLICH  
AUDITOR LAKE COUNTY



CS  
100  
677A

6. That the decedent Jack Fesko's estate was not subject to Indiana inheritance tax.

Further the affiant sayeth not.

*Helen Fesko*

Helen J. Fesko,  
Surviving Spouse

Helen J. Fesko, being first duly sworn upon her oath, states that she is the surviving spouse of the Estate of Jack Fesko, Deceased; that she has read and executed the foregoing Affidavit of Survivorship; and that the matters and things therein set forth are true to the best of her knowledge, information and belief.

This Document is the property of  
the Lake County Recorder!

STATE OF INDIANA )  
COUNTY OF LAKE )

SS:

Subscribed and sworn to before me, the undersigned Notary Public, in and for said County and State, this 18<sup>th</sup> day of December, 1996

8-16-97  
Commission Expires

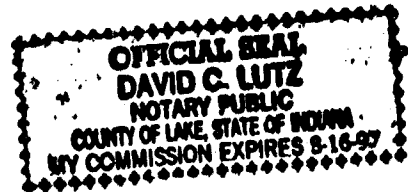
*David C. Lutz*  
Signature of Notary Public

County of Residence  
Lake, Ind.

DAVID C. LUTZ  
Printed of Notary Public

This instrument prepared by: William N. Carden, Attorney at Law, 4954 East 56th Street, Suite 2, Indianapolis, Indiana 46220 (317) 475-9441, FAX (317) 475-9442.

Upon recording please mail to: David C. Lutz, 927 Maxwell Court, Crown Point, Indiana 46307-5009.



**EXHIBIT "A"**

Key # 36-418-46

**Lots 47 and 48, Block 38, Unit 11 of Woodmar, in the City of Hammond, as shown  
in Plat Book 17, page 30, in Lake County, Indiana.**

**More commonly known as: 7015 Indianapolis Blvd., Hammond, IN**



ATTENTION ESTATE: Disclosure of the estate's need to pursue our responsibilities is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

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

Local No. 18

JAN 9 1995  
Date Issued Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) Jack Fesko		2 SEX Male	3a TIME OF DEATH 11:45 AM	3b DATE OF DEATH (Month Day Year) January 6, 1995	
4 SOCIAL SECURITY NUMBER 303-24-6588	5a AGE—Last Birthday (Year) 71	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) July 23, 1923	
7 BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a WAS DECEDENT A US VETERAN? Yes	8b YEAR LAST SERVED IN US ARMED FORCES? 1945	9a PLACE OF DEATH (Check any one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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. Margaret Mercy Hospital		9c CITY TOWN OR LOCATION OF DEATH Hammond	9d COUNTY OF DEATH Lake		
10 MARITAL STATUS (Specify) Married	11 SURVIVING SPOUSE (If wife give maiden name) Helen Jozwik Fesko	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Real Estate Developer	12b KIND OF BUSINESS/INDUSTRY Shopping Centers		
13a RESIDENCE—STATE Illinois	13b COUNTY Cook	13c CITY TOWN OR LOCATION Crete	13d STREET AND NUMBER 355 Green Briar Lane		
13e ZIP CODE 60417	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? USA	15 WAS DECEDENT OF HISPANIC ORIGIN? <input 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 (9-12) College (1-4 or 8+) 4		18 FATHER'S NAME (First Middle Last) Michael Feczko			
19 MOTHER'S NAME (First Middle Maiden Surname) Anna Molcan			20a INFORMANT'S NAME (Type/Print) Helen Fesko		
20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Green Briar Lane, Crete, IL 60417		20c Relationship Wife			
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" 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 10, 1995 Calumet Park Crematory		21c LOCATION—City or Town, State Merrillville, Indiana	
22a EMBALMER'S NAME Larry D. Anthony		22b EMBALMER'S LICENSE NO. 01001447	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR Larry D. Anthony		24b LICENSE NUMBER (of Licensee) 01001447	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME Anthony & Dziadowicz FH 83002916 9445 Calumet Ave., Munster, In 46321		
26 PART I (Enter the diseases, injuries or complications that caused the death. Do not enter non-specific 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) 1. Intra Cranial Bleed DUE TO (OR AS A CONSEQUENCE OF) 2. Polycythemia - Aplastic Anemia DUE TO (OR AS A CONSEQUENCE OF) 3. Testis Swell Renal Dx DUE TO (OR AS A CONSEQUENCE OF) 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 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	29c MEDICAL LICENSE NO. 848	29d DATE SIGNED (Month Day Year) January 6, 1995	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) S. Mischel, D.O. 222 Douglas Street, Hammond, Indiana 46320					
31 HEALTH OFFICER'S SIGNATURE Franklin J. O. Almeida M.D.			32 DATE FILED (Month Day Year) JAN 09 1995		
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, burning, 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.			