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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

97 NOV 17 AM 10: 26

MORRIS W. CARTER

RETURN TO: JAMES R. BIELEFELD, ESQ.
P.O. BOX 717
CROWN POINT, IN 46307

RELEASE OF MORTGAGE

For a valuable consideration, it is hereby certified that a certain mortgage dated May 29, 1985, securing the principal sum of Three Hundred Fifty Thousand Dollars ($350,000.00) (the "Mortgage"), which Mortgage was duly recorded as Document Number 805771 in the Office of the Recorder of Lake County, Indiana, on June 4, 1985, mortgaging the following described real estate:

Lot 8, Re-Subdivision of Eastwood Subdivision, Unit One to the Town of Schererville, as shown in Plat Book 43, page 46, in Lake County, Indiana.

Commonly known as 645 Moraine Trace, Schererville, Indiana, is hereby **FULLY RELEASED AND SATISFIED.**

Dated this 12 day of November, 1997.

Harriet Zimny

Harriet Zimny, individually and as the survivor of Aloysius Zimny

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, the undersigned, a Notary Public in and for said County and State, this 12 day of November, 1997, personally appeared HARRIET ZIMNY, individually, and as the survivor of Aloysius Zimny, and acknowledged the execution of the foregoing instrument.

In witness whereof, I have hereunto subscribed my name and affixed my official seal.

NOTARY PUBLIC SEAL INDIANA

Connie M. Havlin
Notary Public

Printed Name: Connie M. Havlin

My Commission Expires:
December 25, 1998

County of Residence:
Lake

This Instrument prepared by Glenn R. Patterson, Esq., Singleton, Crist, Patterson & Austgen, Suite 200, 9245 Calumet Avenue, Munster, Indiana 46321

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(5)

HOLD FOR FIRST AMERICAN TITLE

FA 21841

1200 fa sn

INDIANA STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

Local No. 4613-89 State No. .....

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

CORONER ONLY

1 DECEASED—NAME (First, Middle, Last): Aloysius Zimny			2 SEX: Male	3a TIME OF DEATH: 5 PM	3b DATE OF DEATH (Month, Day, Yr.): November 17, 1989
4 SOCIAL SECURITY NUMBER: 314-05-0087	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.): April 20, 1919	7 BIRTHPLACE (City and State or Foreign Country): East Chicago, IN
8a WAS DECEDENT A U.S. VETERAN? Yes	8b YEAR LAST SERVED IN U.S. ARMED FORCES? 1946	9a PLACE OF DEATH (Check only one. See instructions.) HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☒ DOA		OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence	
9b FACILITY NAME (If not institution, give street and number): Community Hospital		9c CITY, TOWN OR LOCATION OF DEATH: Munster		9d COUNTY OF DEATH: Lake	
10 MARITAL STATUS (Specify): Married	11 SURVIVING SPOUSE (If wife, give maiden name): Harriet Bylski	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Carpenter		12b KIND OF BUSINESS/INDUSTRY: Construction	
13a RESIDENCE—STATE: Indiana	13b COUNTY: Lake	13c CITY, TOWN OR LOCATION: Griffith		13d STREET AND NUMBER: 624 Rueth Dr.	
13e ZIP CODE: 46319	13f INSIDE CITY LIMITS ☐ No ☒ Yes	13g ON A FARM? ☒ No ☐ Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? ☒ 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):	College (1-4 or 5+): 2				
18 FATHER'S NAME (First, Middle, Last): Stanley Zimny		19 MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Cygan			
20a INFORMANT'S NAME (Type/Print): Harriet Zimny	20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 624 Rueth Dr. Griffith, IN 46319			20c Relationship: Wife	
21a METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify)	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): November 21, 1989 Holy Cross Cemetery			21c LOCATION—City or Town, State: Calumet City, IL	
22a EMBALMER'S NAME: Kevin W. Kish	22b EMBALMER'S LICENSE NO: 1021590	23 WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes			
24a SIGNATURE OF FUNERAL DIRECTOR: Kevin W. Kish	24b LICENSE NUMBER (of Licensee): 1021590	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home#8800135 921 W. 45th Griffith, IN 46319			

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)

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

DUE TO (OR AS A CONSEQUENCE OF): b. Cardiac angina

DUE TO (OR AS A CONSEQUENCE OF): c. CAD Coronary artery

DUE TO (OR AS A CONSEQUENCE OF): d. Adeno Carcinoma of Prostate

Conditions if any which gave rise to the immediate cause stating the underlying cause last

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

NOV 21 1989

LAKE COUNTY HEALTH COMMISSIONER

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)	28a WAS AUTOPSY PERFORMED?	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
N/A		N/A

29a CERTIFIER (Check only one)

☒ 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)
	27477	November 21, 1989

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Aggarwal, M.D. 1360 S. Lake Park Ave Hobart, IN

31 HEALTH OFFICER'S SIGNATURE: [signature]

32 DATE FILED (Month, Day, Year): NOV 21, 1989

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.

SBH06-004 State Form 10110 (R2/3-89) DEA CERT/PD 1