

97 DEC 10 AM 10:10

MORRIS W. CARTER  
CLERK

STATE OF INDIANA )

) SS: 97084418

COUNTY OF LAKE )

C 495155 LP

AFFIDAVIT

The undersigned, CHRISTINE A. KLOUSE <sup>aka Christine Klouse</sup> and MARY ANN SULLIVAN, being first duly sworn upon oath, state as follows:

1. That your affiants are sisters, born of the marriage of JOHN C. KRECZMER and WANDA JENNIE KRECZMER.

2. That the undersigned, CHRISTINE A. KLOUSE, currently resides at 402 Harborgate Court, Cornelius, North Carolina, 28031.

3. That the undersigned, MARY ANN SULLIVAN, currently resides at 9220 N. W. 14th Court, Plantation, Florida, 33322.

4. That your affiants are the sole heirs at law of JOHN C. KRECZMER and WANDA JENNIE KRECZMER.

5. That JOHN C. KRECZMER, father of your affiants, passed away on the 21st day of September, 1992; that WANDA JENNIE KRECZMER, mother of your affiants, passed away on the 10th day of January, 1995.

6. That during the decedents' lifetimes, they were the owners of the following described real estate:

Lot 16, Block 7, Subdivision of the East 1510.2 feet of the North 1320 feet of the Northwest Quarter of Section 32 Township 37 North, Range 9 West of the 2nd P. M., except the East 201 feet thereof, in the City of East Chicago, as shown in Plat Book 2, page 16, in Lake County, Indiana.

FILED FOR TAXATION SUBJECT TO ACCEPTANCE FOR TRANSFER DEC 09 1997

7. That on the 6th day of September, 1989, the parents of your affiants conveyed the real estate described hereinabove to your affiants as tenants in common, retaining therein a life estate. That as a result of the death of your affiants' parents, they are now the owners in fee simple of the real estate described in paragraph 6 above.

WAM... ADULT...

8. That at the time your affiants' mother passed away, she owned no property, either real nor personal.

9. That your affiants are Class A beneficiaries as defined in West's A. I. C. 6-4.1-1-3 and accordingly are entitled to combined exemptions of \$10,000.00 as more specifically defined in West's A. I. C. 6-4.1-3-10.

000622

MRS

1500  
at  
su

Chicago Title Insurance Company

10. That the total value of all property to which your affiants succeeded or received from the decedents is less than \$10,000.00 and accordingly exempt from Indiana inheritance taxes.

Further affiants saith not.

Christine A. Klouse  
CHRISTINE A. KLOUSE

Mary Ann Sullivan  
MARY ANN SULLIVAN

STATE OF NORTH CAROLINA, COUNTY OF MECKLENBURG, SS:

Before me, the undersigned, a Notary Public in and for said County and State, personally appeared the within named CHRISTINE A. KLOUSE who acknowledged the execution of the foregoing Deed to be her voluntary act and deed.

Witness, my hand and Official Seal this 24<sup>th</sup> day of November, 1997.

[Signature]  
Notary Public

My Commission Expires: 12/18/98  
County of Residence of Notary Public: Mecklenburg

STATE OF FLORIDA, COUNTY OF Broward, SS:

Before me, the undersigned, a Notary Public in and for said County and State, personally appeared the within named MARY ANN SULLIVAN who acknowledged the execution of the foregoing Deed to be her voluntary act and deed.

Witness, my hand and Official Seal this 24<sup>th</sup> day of December, 1997.

Bette dos Santos  
Notary Public

My Commission Expires: August 1, 1998  
County of Residence of Notary Public: Broward

**FILED**  
BETTE DOS SANTOS  
MY COMMISSION # CC396857 EXPIRES August 1, 1998  
BONDED THROUGH FAITH INSURANCE, INC.

This instrument prepared by JOHN R. SORBELLO, attorney at law.

INDIANA STATE BOARD OF HEALTH

TAX KEY # 30-163-16

Local No. 2033-92

CERTIFICATE OF DEATH

State No. ....

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

1 DECEASED—NAME (First, Middle, Last) <b>John C. Kreczmer</b>		2 SEX <b>Male</b>		3a TIME OF DEATH <b>10:00PM</b>		3b DATE OF DEATH (Month, Day, Yr.) <b>Sep 21 1992</b>	
4 SOCIAL SECURITY NUMBER <b>312 10 6997</b>		5a AGE—Last Birthday (Year) <b>78</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes	
5d DATE OF BIRTH (Mo. Day, Yr.) <b>Jun 9 1914</b>		7 BIRTHPLACE (City and State or Foreign Country) <b>East Chicago In</b>					
8a WAS DECEASED A U.S. VETERAN? <b>Yes</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>1946</b>		9a PLACE OF DEATH (Check only 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) <b>Munster Community Hospital</b>				9c CITY, TOWN OR LOCATION OF DEATH <b>Munster</b>		9d COUNTY OF DEATH <b>Lake</b>	
10 MARITAL STATUS <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>Wanda Malewski</b>		12a DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Technician</b>		12b KIND OF BUSINESS/INDUSTRY <b>Chemical</b>	
13a RESIDENCE—STATE <b>Indiana</b>		13b COUNTY <b>Lake</b>		13c CITY, TOWN, OR LOCATION <b>East Chicago</b>		13d STREET AND NUMBER <b>5032 Northcote Ave</b>	
13e ZIP CODE <b>46312</b>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>		15 WAS DECEASED 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) <b>White</b>		17 DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>					
18 FATHER'S NAME (First, Middle, Last) <b>Stanley Kreczmer</b>				19 MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Czak</b>			
20a INFORMANT'S NAME (Type/Print) <b>Wanda Kreczmer</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5032 Northcote E. Chicago In 46312</b>		20c Relationship <b>Wife</b>	
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) <b>Sep 24 1992 Ridge Lawn Cemetery</b>			21c LOCATION—City or Town, State <b>Gary In</b>		
22a EMBALMER'S NAME <b>James W. Gholston</b>		22b EMBALMER'S LICENSE NO. <b>FD01004194</b>		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>John B. ...</i>		24b LICENSE NUMBER (of Licensee) <b>FD01005491</b>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>Lesniak FH83001601 4918 Magoun E. Chicago In 46312</b>			
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. <b>Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF) b. <b>renal failure</b> DUE TO (OR AS A CONSEQUENCE OF) Conditions if any, which gave rise to the immediate cause, stating the underlying cause last c. <b>myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF) <b>COMPLETE CORONARY ARTERY DISEASE</b> <b>DEATH OF THE HEART</b>							
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I <b>SEP 28 1992</b>							
27 WAS DECEASED PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)		28a WAS AN AUTOPSY PERFORMED? <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)		28c DATE SIGNED (Month, Day, Year) <b>9/28/92</b>	
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) as stated.							
29b SIGNATURE AND TITLE OF CERTIFIER <i>Don H. Dumont MD</i>				29c MEDICAL LICENSE NO. <b>01033457</b>		29d DATE SIGNED (Month, Day, Year) <b>9/28/92</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Don H. Dumont MD 761 45th Ave Munster In 46321</b>							
31 HEALTH OFFICER'S SIGNATURE <i>Alexander Williams, MD</i>						32 DATE FILED (Month, Day, Year) <b>September 28, 1992</b>	
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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) <b>000627</b>	
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

**FILED**

I CERTIFY THAT THIS IS A TRUE COPY OF THE ORIGINAL CERTIFICATE

JUDITH A. GIBSON, REGISTER OF DEEDS

BY: Kindelby D. G...

DEPUTY

TAX UNIT # 24

TAX KEY # 30-163-16

NORTH CAROLINA DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES  
DIVISION OF EPIDEMIOLOGY - VITAL RECORDS SECTION

CERTIFICATE OF DEATH

Registration District No. 06095 Local No.

1. DECEDECENT'S NAME (First, Middle, Last) Wanda Jennie Kreczmer 2. SEX F 3. DATE OF DEATH (Month, Day, Year) January 10, 1995

4. SOCIAL SECURITY NUMBER 067-16-1948 5. AGE—Last Birthday (Years) 72 5b. UNDER 1 YEAR Months Days 5c. UNDER 1 DAY Hours Minutes 6. DATE OF BIRTH (Month, Day, Year) Jul. 1, 1922 7. BIRTHPLACE (County and State or Foreign Country) Brooklyn, NY

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No) No 9a. PLACE OF DEATH (Check only one) HOSPITAL  Inpatient  ER/Outpatient  DOA OTHER:  Nursing Home  Residence  Other (Specify)

9b. FACILITY NAME (If not institution, give street and number) Britthaven Nursing Center 9c. CITY, TOWN, OR LOCATION OF DEATH Charlotte 9d. INSIDE CITY LIMITS? (Yes or No) Yes 9e. COUNTY OF DEATH Mecklenburg

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify) Widowed 11. SURVIVING SPOUSE (If wife, give maiden name) 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) School Crossing Guard 12b. KIND OF BUSINESS/INDUSTRY City of E. Chicago

13a. RESIDENCE—STATE NC 13b. COUNTY Mecklenburg 13c. CITY, TOWN, OR LOCATION Charlotte 13d. STREET AND NUMBER 2623 Cranbrook Lane

13e. INSIDE CITY LIMITS? (Yes or No) Yes 13f. ZIP CODE 28207 14. Was Decedent of Hispanic Origin? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes  No (Specify) 15. RACE—American Indian, Black, White, Etc. (Specify) White 16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (13-17+) 8

17. FATHER'S NAME (First, Middle, Last) Benjamin Malewski 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Wozniak

19a. INFORMANT'S NAME (Type/Print) Christine Klouse 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Edgewater Dr., Charlotte, NC 28210 19c. DATE AMENDED

Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. If appropriate, enter tobacco, alcohol, or drug use. List only one cause on each line. (PRINT or TYPE)

IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Congestive Heart Failure b. Valvular Heart Disease c. d. Approximate Interval Between Onset and Death 1 yr

20a. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, such as tobacco, alcohol, or drug use; diabetes, etc.

20b. End Stage Renal Disease, Malnutrition

21a. AUTOPSY? (Yes or No) NO 21b. If Yes, were findings considered in determining cause of death? 21c. Was case referred to Medical Examiner? (Yes or No) 22. TIME OF DEATH

NOTICE: STATE LAW REQUIRES THAT ALL DEATHS DUE TO TRAUMA, ACCIDENT, HOMICIDE, SUICIDE, OR UNDER SUSPICIOUS, UNUSUAL, OR UNNATURAL CIRCUMSTANCES BE REPORTED TO, AND CERTIFIED BY A MEDICAL EXAMINER ON A MEDICAL EXAMINER'S CERTIFICATE OF DEATH. ANY DEATH FALLING INTO THESE CATEGORIES IS WITHIN THE MEDICAL EXAMINER'S JURISDICTION REGARDLESS OF THE LENGTH OF SURVIVAL FOLLOWING THE UNDERLYING INJURY.

23a. SIGNATURE AND TITLE OF CERTIFIER Kathleen A. Doman MD 23b. DATE SIGNED (Month, Day, Year) 1-13-95

24. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type or Print) Kathleen A. Doman, M.D. 908 Pecan Avenue Charlotte, NC 28205

25a. METHOD OF DISPOSITION  Burial  Cremation  Removal  Donation  Other 25b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Ridgeland Cemetery 25c. LOCATION—City or Town, State, Zip Code Gary, IN

26a. NAME AND ADDRESS OF FUNERAL HOME Harry and Bryant Co. Charlotte, NC 28207 26b. SIGNATURE OF FUNERAL DIRECTOR James H. Wilkins 26c. LICENSE NUMBER 683

27. DATE FILED (Month, Day, Year) 1-19-95 28. SIGNATURE OF EMBALMER Thomas Greg Murray 28a. LICENSE NUMBER 1848

DECEDENT

PARENTS

INFORMANT

CAUSE OF DEATH

CERTIFIER

DISPOSITION

DEHNR 1872 (Revised 2/94 Review 2/97) VITAL RECORDS

00062