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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

FILED

97088760

97 DEC 26 AM 11:49 DEC 23 1997

MORRIS W. CARTER  
AUDITOR  
LAKE COUNTY

STATE OF INDIANA )  
                          ) SS:  
COUNTY OF LAKE )

AFFIDAVIT OF SURVIVORSHIP

Comes now HELEN GRONKIEWICZ, being duly sworn upon her oath, and states as follows:

That the Affiant is the owner in fee simple of the following described real estate located in Lake County, Indiana, more particularly described as follows:

Lot 6 except the West 17 feet thereof, all of Lot 7 and the West 9 feet of Lot 8 in Block 2 in Hammond Steel City Addition to Hammond, as per plat thereof, recorded in Plat Book 17 page 18, in the Office of the Recorder of Lake County, Indiana.  
Key No: 34-30-7 Unit# 26.

Commonly known as 642 139th Street, Hammond, Indiana.

That the decedent STANLEY J. GRONKIEWICZ, and the Affiant acquired title as joint tenants with right of survivorship to said real estate by deed of conveyance on the 25th day of October, 1996, and recorded in the Office of the Lake County Recorder.

That the decedent and the Affiant jointly held title to said real estate until the death of STANLEY GRONKIEWICZ on the 13th day of October, 1997, at which time this Affiant acquired title to the real estate as the surviving joint tenant pursuant to property law. A certified copy of the Death Certificate of STANLEY J. GRONKIEWICZ is attached hereto, and marked as Exhibit "A."

001470

1300  
1178

That the gross value of the estate of the decedent as determined for the purpose of Federal Estate Taxes, was less than the value required for the filing of a Federal Estate Tax Return; therefore, the decedent's estate was not subject to Federal Estate Tax.

That the decedent's estate was not subject to Indiana Inheritance Taxes.

*Helen Gronkiewicz*  
HELEN GRONKIEWICZ,  
Affiant

STATE OF INDIANA     )  
                                  ) SS:  
COUNTY OF LAKE     )

Subscribed and sworn to before me, this 26 day of  
NOVEMBER, 1997.

*[Signature]*  
\_\_\_\_\_  
NOTARY PUBLIC

County of Residence: Lake

My Commission Expires:

10-10-2001

Robert B. Leopold  
8242 Columet Ave.  
Munster, In. 46321

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

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

CERTIFICATE OF DEATH

Local No. 806

Date Issued 10-17-1997  
Hammond Health Commissioner

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------|
| 1 DECEASED—NAME (First Middle Last)<br><b>STANLEY J. GRONKIEWICZ</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               | 2 SEX<br><b>MALE</b>                                                                                                                         | 3a TIME OF DEATH<br><b>12:25 P.M.</b>                                                                                                                                                                                                                                                                               | 3b DATE OF DEATH (Month, Day, Year)<br><b>OCTOBER 13, 1997</b>              |                                  |
| 4. *SOCIAL SECURITY NUMBER<br><b>306-10-8475</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5a AGE—Last Birthday (Years)<br><b>79</b>                                                     | 5b UNDER 1 YEAR<br>Months: Days:                                                                                                             | 5c UNDER 1 DAY<br>Hours: Minutes:                                                                                                                                                                                                                                                                                   | 6 DATE OF BIRTH (Mo, Day, Yr)<br><b>MAY 8, 1918</b>                         |                                  |
| 7 BIRTHPLACE (City and State or Foreign Country)<br><b>HAMMOND, INDIANA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 8a WAS DECEDENT A U.S. VETERAN?<br><b>YES</b>                                                 | 8b YEAR LAST SERVED IN U.S. ARMED FORCES?<br><b>1944</b>                                                                                     | 9a PLACE OF DEATH (Check only one. See instructions)<br>HOSPITAL <input type="checkbox"/> Inpatient<br><input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)<br><input checked="" type="checkbox"/> Residence |                                                                             |                                  |
| 9b FACILITY NAME (If not institution, give street and number)<br><b>642 139TH STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 9c CITY, TOWN OR LOCATION OF DEATH<br><b>HAMMOND</b>                                                                                         | 9d COUNTY OF DEATH<br><b>LAKE</b>                                                                                                                                                                                                                                                                                   |                                                                             |                                  |
| 10 MARITAL STATUS (Specify)<br><b>MARRIED</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11 SURVIVING SPOUSE (If wife, give maiden name)<br><b>HELEN STERNA</b>                        | 12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)<br><b>MACHINE OPERATOR</b>          | 12b KIND OF BUSINESS/INDUSTRY<br><b>MANUFACTURING</b>                                                                                                                                                                                                                                                               |                                                                             |                                  |
| 13a RESIDENCE—STATE<br><b>INDIANA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 13b COUNTY<br><b>LAKE</b>                                                                     | 13c CITY, TOWN OR LOCATION<br><b>HAMMOND</b>                                                                                                 | 13d STREET AND NUMBER<br><b>642 139TH STREET</b>                                                                                                                                                                                                                                                                    |                                                                             |                                  |
| 13e ZIP CODE<br><b>46327</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 13f INSIDE CITY LIMITS<br><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | 14 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 | 15 WAS DECEDENT OF HISPANIC ORIGIN?<br><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)<br><b>WHITE</b>       |                                  |
| 17 DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (10-12) <b>10</b><br>College (1-4 or 5+) <b>10</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               | 18 FATHER'S NAME (First Middle Last)<br><b>ALEX GRONKIEWICZ</b>                                                                              |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| 19 MOTHER'S NAME (First Middle Maiden Surname)<br><b>JOSEPHINE MASTY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                                                                              | 20a INFORMANT'S NAME (Type/Print)<br><b>HELEN B. GRONKIEWICZ</b>                                                                                                                                                                                                                                                    |                                                                             |                                  |
| 20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>642 139TH STREET HAMMOND, INDIANA 46327</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               | 20c Relationship<br><b>WIFE</b>                                                                                                              |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| 21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                        |                                                                                               | 21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OCTOBER 16, 1997<br/>OAKLAND MEMORY LANES CREMATORY</b> |                                                                                                                                                                                                                                                                                                                     | 21c LOCATION—City or Town, State<br><b>DOLTON, ILLINOIS</b>                 |                                  |
| 22a EMBALMER'S NAME<br><b>LEO V. HENNESSY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               | 22b EMBALMER'S LICENSE NO.<br><b>IL 034-010388</b>                                                                                           | 23 WAS DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                                                                            |                                                                             |                                  |
| 24a SIGNATURE OF FUNERAL DIRECTOR<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               | 24b LICENSE NUMBER (of Licensee)<br><b>29300133</b>                                                                                          | 25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME # <b>287</b><br><b>MCCOY FUNERAL CHAPEL 5713 HOHMAN AVE.<br/>HAMMOND, IN FOR HENNESSY-NOWAK FUNERAL<br/>HOME 400 PULASKI RD. CALUMET CITY, IL</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>END STAGE PARINSONSON'S DYSBASIS</b>                                                                                                   |                                                                                                                                                                                                                                                                                                                     | <b>YEARS</b>                                                                |                                  |
| Conditions if any which gave rise to the immediate cause stating the underlying cause last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               | b. <b>CARCINOMA OF THE PROSTATE</b>                                                                                                          |                                                                                                                                                                                                                                                                                                                     | <b>YEARS</b>                                                                |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               | c. <b>CORONARY ARTERY DYSBASIS</b>                                                                                                           |                                                                                                                                                                                                                                                                                                                     | <b>YEARS</b>                                                                |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               | d. <b>OLD MYOCARDIAL INFARCTION</b>                                                                                                          |                                                                                                                                                                                                                                                                                                                     | <b>YEARS</b>                                                                |                                  |
| PART II Other significant conditions contributing to death but not previously stated in Part I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| <b>OVERTICULOSIS<br/>ANEMIA - CHRONIC</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| 27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 28a WAS AN AUTOPSY PERFORMED? (Yes or no)<br><b>NO</b>                                                                                       |                                                                                                                                                                                                                                                                                                                     | <b>FILED<br/>COMPLETION OF CAUSE OF DEATH? (Yes or no)<br/>DEC 23 1997</b>  |                                  |
| 29a CERTIFIER (Check only one)<br><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<br><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<br><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<br><i>[Signature]</i><br><b>SAM ORLICH<br/>AUDITOR LAKE COUNTY</b>                                      |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| 29c MEDICAL LICENSE NO.<br><b>02007161</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                               | 29d DATE FILED (Month, Day, Year)<br><b>OCTOBER 15, 1997</b>                                                                                 |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)<br><b>DR. C.A. FOREIT 3831 HOHMAN AVE. HAMMOND, INDIANA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |
| 31 HEALTH OFFICER'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                                              |                                                                                                                                                                                                                                                                                                                     | 32 DATE FILED (Month, Day, Year)<br><b>October 17, 1997</b>                 |                                  |
| 33 MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined<br><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) |                                  |
| 34g DATE PRONOUNCED DEAD (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               | 34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.<br><b>001477</b>                                  |                                                                                                                                                                                                                                                                                                                     |                                                                             |                                  |