

3.

98049643

98 JUL 1 1998  
NOTARY PUBLIC

STATE OF INDIANA }  
                          } SS:           IN RE: MAGDALENE S. MOSKALICK, DECEDENT  
COUNTY OF LAKE    }

**AFFIDAVIT FOR TRANSFER OF REAL PROPERTY**

Mariann (Moskalick) Walsh, being first duly sworn upon her oath affirms and states:

1. That the above-named decedent died intestate on April 24, 1998, while domiciled in Lake County Indiana, as shown by a certified copy of decedent's death certificate attached hereto, made a part hereof and marked Exhibit "1".

2. That forty-five (45) days have elapsed since the death of the decedent.

3. That no application or petition for the appointment of a personal representative is pending or had been granted in any jurisdiction nor is any administration contemplated.

4. That the following named persons are the only heirs of the decedent:

- a. Adolph G. Moskalick (husband)  
2905 - 163rd Place  
Hammond, Indiana 46323
- b. Mariann (Moskalick) Walsh (daughter)  
15536 Village Drive  
Lake Oswego, Oregon 97034-3750

5. That the value of the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the allowance provided by I.C. §29-1-4-1, the costs and expenses of administration and reasonable funeral expenses.

**FILED**

JUL 01 1998

Exhibit "A"

1 SAM ORLICH  
AUDITOR LAKE COUNTY

000120

12/10  
SM  
CS

Timothy Kelly 9250 Columbia Ave. Ste 21 Menasha WI 53251 ←

6. That among the decedent's probate assets is a parcel of real estate which was owned by the decedent located in Lake County, Indiana, more particularly described as follows:

Lot No. Twenty-seven (27), in Block "C", as marked and laid down on the recorded plat of Parkland Terrace Addition, Hammond, Lake County, Indiana, as the same appears of record in Plat Book 24, page 18 in the Recorder's Office of Lake County, Indiana. Commonly known as: 2905 - 163rd Place, Hammond, Indiana.

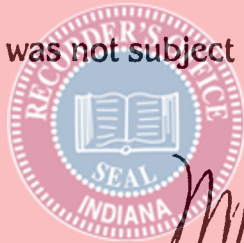
7. That there are no creditors of decedent's estate.

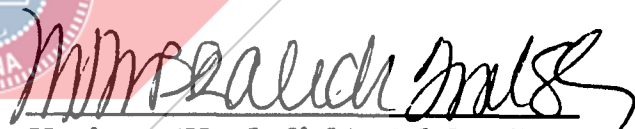
8. That the individuals entitled to the real estate as a result of decedent's death are Adolph G. Moskalick (husband) and Mariann (Moskalick) Walsh (daughter).

9. That the gross value of the estate of the decedent, Magdalene S. Moskalick, as determined for the purposes of Federal Estate taxes, was less than the value required for the filing of a Federal Estate Tax Return. As a consequence thereof, the decedent's estate was not subject to Federal Estate Tax.

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

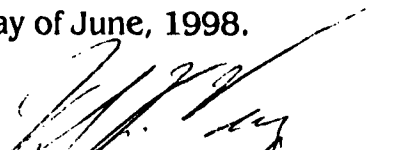
**Further affiant sayeth not.**





**Mariann (Moskalick) Walsh, Affiant**

**SUBSCRIBED AND SWORN** to before me, this 30th day of June, 1998.

  
**Karl K. Vanzo, Notary Public**

My Commission Expires: November 4, 1998

County of Residence: Lake

\* ATTENTION ESTATE: Disclosure of the SS# we 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 INDIANA HEALTH DEPARTMENT.

Local No. 341

St. Franklin D. Remade, M.D.  
Date Issued: April 27, 1998  
Hammond Health Commission

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

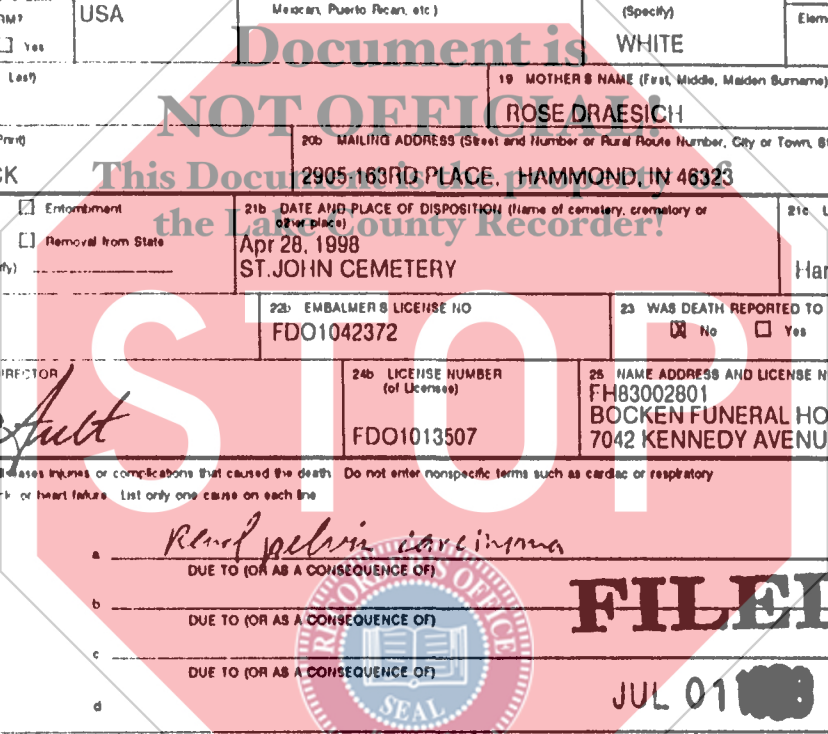
PARENTS

INFORMANT

DISPOSITION

CAUSE OF  
DEATH

1 DECEASED NAME (First Middle Last) <b>MAGDALENE S. MOSKALICK</b>				2 SEX <b>Female</b>		3a TIME OF DEATH <b>9:58PM</b>		3b DATE OF DEATH (Month Day Year) <b>April 24, 1998</b>		
4 SOCIAL SECURITY NUMBER <b>351-10-6939</b>		5a AGE - Last Birthday (Years) <b>79</b>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo Day Yr) <b>Jun 17, 1918</b>		
7 BIRTHPLACE (City and State or Foreign Country) <b>EAST CHICAGO, IN</b>		8a WAS DECEDENT A U.S. VETERAN? <b>No</b>		8b YEAR LAST SERVED IN U.S. ARMED FORCES <b>N/A</b>		8c 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				
9a FACILITY NAME (If not institution, give street and number) <b>ST. MARGARET-MERCY HEALTH CARE</b>				9b CITY/TOWN OR LOCATION OF DEATH <b>HAMMOND</b>			9c COUNTY OF DEATH <b>LAKE</b>			
10 MARITAL STATUS (Specify) <b>Married</b>		11 SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</b>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>SCHOOL CAFETERIA WORKER</b>			12b KIND OF BUSINESS INDUSTRY <b>HAMMOND SCHOOL SYSTEM</b>			
13a RESIDENCE - STATE <b>IN</b>		13b COUNTY <b>LAKE</b>		13c CITY/TOWN OR LOCATION <b>HAMMOND</b>			13d STREET AND NUMBER <b>2905-163RD PLACE</b>			
13e ZIP CODE <b>46323</b>		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? <b>USA</b>		15 WAS DECEDENT 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 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		18 FATHER'S NAME (First Middle Last) <b>JOHN SKERTIC</b>				19 MOTHER'S NAME (First Middle, Maiden Surname) <b>ROSE DRAESICH</b>				
20a INFORMANT'S NAME (Type Print) <b>ADOLPH MOSKALICK</b>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2905-163RD PLACE, HAMMOND, IN 46323</b>			20c Relationship <b>Husband</b>			
21a METHOD OF DISPOSITION <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>Apr 28, 1998 ST. JOHN CEMETERY</b>			21c LOCATION - City or Town State <b>Hammond, IN</b>				
22a EMBALMER'S NAME <b>CHARLES WELLS</b>			22b EMBALMER'S LICENSE NO. <b>FDO1042372</b>			23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR <i>John P. Ault</i>			24b LICENSE NUMBER (of License) <b>FDO1013507</b>			25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>FH83002801 BOCKEN FUNERAL HOME, INC. 7042 KENNEDY AVENUE, Hammond, IN 46323</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) <b>Renal pelvic carcinoma</b> a DUE TO (OR AS A CONSEQUENCE OF)										
Conditions if any which gave rise to the immediate cause stating the underlying cause last b DUE TO (OR AS A CONSEQUENCE OF)										
c DUE TO (OR AS A CONSEQUENCE OF)										
d										
27 PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I						28 WAS DECEDENT PREGNANT OR BORN POSTPARTUM? (Yes or no) <b>SAM ORLICH AUDITOR LAKE COUNTY</b>		29 WAS AN AUTOPSY PERFORMED? <b>No</b>	30 WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>No</b>	
24a 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) and manner as stated										
25b SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						25c MEDICAL LICENSE NO. <b>33509</b>		25d DATE SIGNED (Month Day Year) <b>4-27-98</b>		
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 25) (Type Print) <b>Howard M. Mishoulam, M.D. 1630-45th Avenue Munster, IN 46321</b>										
31 HEALTH OFFICER'S SIGNATURE <i>Franklin D. Remade, M.D.</i>						32 DATE FILED (Month Day Year) <b>April 27, 1998</b>				
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 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.							



**FILED**  
JUL 01 1998

000121