MORRIS W. CARTER RECORDER MAR 2 0 2000

PETER BENJAMIN
LAKE COUNTY AUDITOR

On this 2/29/2000 (insert date) before me personally appeared

RONALD M. WITCZAK

to me personally known, who being duly sworn on oath did say that:

1. Affiant resides at the address given below affiant's signature;

2. Affiant is Son and named Administrator (state interest of affiant in the above premises as "owner," "son of owner," etc.);

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by AMELIA WITCZAK a/k/a EMILY WITCZAK and MATTHEW B. WITCZAK;

4. Said MATTHEW B. WITCZAK (fill in name of co-tenant who died)

died on 12-29-97

leaving NO (insert "a" or "no"; if will left, attach a copy) will; but survived by Wife, AMELIA WITCZAK;

5. The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, and insurance does not exceed the sum of $ 0.00 and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of said decedent;

6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? NO

(If answer is "Yes," identify the divorce proceedings:

);

7. Affiant's relationship to the deceased was Son.

Signature: Ronald M. Witczak
Ronald M. Witczak
515 West Columbus Dr.
Address: East Chicago, IN

Subscribed and sworn to before me by the affiant this 29 day of Feb, 2000 (insert date)

Suzanne Goldsmith
SUZANNE Notary Public GOLDSMITH

My Commission Expires 11/27/2007

This instrument prepared by SUZANNE GOLDSMITH Attorney at Law

NORTHWEST INDIANA TITLE SERVICES, INC.
162 Washington Street
Lowell, Indiana 46356
00-8536

1200 E.P.

U940

* 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

CERTIFICATE OF DEATH

Local No. 324 State No. .....

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr)
Matthew B. Witczak	Male	11:18p M	December 29, 1997

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR Months / Days	5c. UNDER 1 DAY Hours / Minutes	6. DATE OF BIRTH (Mo, Day, Yr)	7. BIRTHPLACE (City and State or Foreign Country)
306-03-8805	78			March 29, 1919	East Chicago, Ind:

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
Yes	1949	HOSPITAL ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Catherine Hospital	East Chicago	Lake

10. MARITAL STATUS (Specify)	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)	12b. KIND OF BUSINESS/INDUSTRY
Married	Amelia M. Pitzel	Crane Operator	General American Trans. C

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	East Chicago	515 West Columbus Drive

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc)	16. RACE—American Indian, Black, White, etc. (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5 +)
46312	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	12

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Joseph Witczak	Helen Ostrowski

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Amelia M. Witczak	515 W.Columbus Dr.,East Chgo.,IND 46312	Wife

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	January 2, 1998 Holy Cross Cemetery	Calumet City, Illi:

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO.	23. WAS DEATH REPORTED TO CORONER?
James H. Fife	FD01010795	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
John B. Fife	FD01020366	FIFE FUNERAL HOME - FH8300151. 4201 Indpls.Blvd.,E.Chgo,IND

CAUSE OF DEATH

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. ✓ Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF)
b.
DUE TO (OR AS A CONSEQUENCE OF)
c.
DUE TO (OR AS A CONSEQUENCE OF)
d.

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

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 AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
No	No	-

CERTIFIER

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)
J Robert	✓ 1035958	Dec. 31, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print)
Dr. Ravi Bhagwat, M.D. - 5500 Hohman Ave., Hammond, Indiana 46320

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE	32. DATE FILED (Month, Day, Year)
Dr. Timothy Rayfordich	1-5-98

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.

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