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STATE OF INDIANA)
COUNTY OF LAKE)

)SS: 2002 016344

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2002 FEB 14 PM 2:01
MORRIS W. CARTER
RECORDER

AFFIDAVIT OF SURVIVORSHIP

Comes now Stephany Kowalczyk, and upon being duly sworn does attest and say:

1. That the affiant is the spouse of Robert Kowalczyk, deceased.
2. That Stephany Kowalczyk and Robert Kowalczyk were the owners as Tenants by the Entirety of real property located in Lake County, Indiana, more particularly described as:

Key #18-250-30

Lot 30 in Lake Park Manor Addition to the City of Hobart as recorded in Plat Book 30 page 63, in the Office of the Recorder of Lake County, Indiana.
3. That Stephany Kowalczyk and Robert Kowalczyk acquired the property during the term of their marriage.
4. That Stephany Kowalczyk and Robert Kowalczyk remained married until the death of Robert Kowalczyk on the 17th day of June, 1996.
5. That Stephany Kowalczyk became the fee simple owner of the property at the death of Robert Kowalczyk.

I affirm under the penalties for perjury that the foregoing statements are true.

STATE OF INDIANA)
COUNTY OF LAKE)

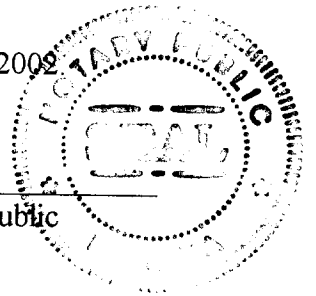
Stephany Kowalczyk
Stephany Kowalczyk

Subscribed and sworn to before me this 14 day of February, 2002.

My Commission
Expires: 7-5-02



Patricia A. Rees
Patricia A. Rees, Notary Public
Resident of Lake County



~~This Instrument Prepared by: Patricia A. Rees, P.O. Box 488, Hobart, IN 46342. Telephone: (219) 947-1692.~~

FILED

FEB 14 2002

PETER BENJAMIN
LAKE COUNTY AUDITOR

000889

Handwritten initials and date

10cc's + 2v

* 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

Local No. 2158-96

CERTIFICATE OF DEATH

State No.

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

41107
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Key# 18-250-30
unit # 27
Lake Park Manor
hot 30

1. DECEASED—NAME (First Middle Last) ROBERT KOWALCZYK		2. SEX Male	3a. TIME OF DEATH 9:55AM	3b. DATE OF DEATH (Month Day Yr) June 17, 1996	
4. SOCIAL SECURITY NUMBER 312-05-4521	5a. AGE - Last Birthday (Years) 77	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo Day Yr) Jul 6, 1918	
7. BIRTHPLACE (City and State or Foreign Country) Gary, Indiana	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES WWII	9a. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)		
9b. FACILITY NAME (If not institution, give street and number) St. Mary Medical Center		9c. CITY TOWN OR LOCATION OF DEATH Hobart	9d. COUNTY OF DEATH Lake		
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Stephany Bozek	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Electrician		12b. KIND OF BUSINESS INDUSTRY Steel	
13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY TOWN OR LOCATION Hobart	13d. STREET AND NUMBER 819 S. Ash Street		
13e. ZIP CODE 46342	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) White	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		18. FATHER'S NAME (First, Middle, Last) Samuel Kowalczyk			
19. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Potaczek		20a. INFORMANT'S NAME (Type/Print) Stephany Kowalczyk			
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 S. Ash Street, Hobart, IN 46342		20c. Relationship Wife			
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Jun 20, 1996 Calumet Park Cemetery		21c. LOCATION - City or Town State Merrillville, Indiana	
22a. EMBALMER'S NAME James J. Krause		22b. EMBALMER'S LICENSE NO. FDO1006463	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a. SIGNATURE OF FUNERAL DIRECTOR <i>James J. Krause</i>		24b. LICENSE NUMBER (of Licensee) FDO1006463	25. NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83003069 Reas Funeral Home, Inc. 600 W. Old Ridge Road, Hobart, IN 46342		
26. THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH TO BE FILED WITH THE LAKE COUNTY HEALTH DEPT. IMMEDIATE CAUSE (From disease or condition resulting in death) MI 29 1996 Conditions if any which may be underlying Coronary artery disease Carotid atherosclerosis a. Coronary artery atherosclerosis b. Carotid atherosclerosis c. Carotid atherosclerosis d. Carotid atherosclerosis Approximate Interval Between Onset and Death 4 weeks 1 year					
PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Coronary artery disease Carotid atherosclerosis					
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No		28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
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>Ernest Mirich MD</i>		29c. MEDICAL LICENSE NO. 15511	29d. DATE SIGNED (Month Day Year) 6/18/96		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print) Ernest Mirich MD, 9001 Broadway, Merrillville, IN 46410					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>					
32. DATE FILED (Month Day Year) June 18, 1996					
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) FEB 14 2002	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) 000890			
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			

PETER BENJAMIN
LAKE COUNTY AUDITOR