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2002 FEB 26 AM 10:38

AFFIDAVIT

MICHAEL A. BROWARTER
RECORDER

STATE OF INDIANA)
)SS:
COUNTY OF LAKE)

DIANE M. PIETERS, BEING FIRST DULY SWORN UPON HER OATH, DEPOSES AND SAYS:

THAT STELLA C. OLSZEWSKI DIED ON THE 24th DAY OF October, 2001, AT The Community Hospital, AND THAT AT THE TIME OF HER DEATH, SHE WAS A CO-OWNER AS A JOINT TENANT WITH DIANE M. PEITERS OF THE FOLLOWING DESCRIBED REAL ESTATE:

LOT 37 IN BLOCK 1 IN BEVERLY EIGHTH ADDITION, IN THE CITY OF HAMMOND, AS PER PLAT THEREOF, RECORDED MARCH 23, 1955 IN PLAT BOOK 30 PAGE 68, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

COMMONLY KNOWN AS 7749 CATALPA, HAMMOND, IN. 46324

UNIT 26 KEY NO. 32-210-37

THAT NO FEDERAL ESTAT TAX OR INDIANA INHERITANCE TAX IS DUE AS A RESULT OF THE DEATH OF STELLA C. OLSZEWSKI.

THAT THE AFFIANT'S RELATIONSHIP TO THE DECEDENT WAS DAUGHTER.

FURTHER AFFIANT SAITH NOT.

COMMUNITY TITLE COMPANY
FILE NO L 22818

Diane M. Pieters
DIANE M. PIETERS

BEFORE ME, THE UNDERSIGNED NOTARY PUBLIC IN AND FOR SAID COUNTY AND STATE, THIS 12th DAY OF February, 2002, PERSONALLY APPEARED DIANA M. PIETERS AND ACKNOWLEDGED THE EXECUTION OF THE ABOVE DOCUMENT.

FILED

MY COMMISSION EXPIRES:

Karen Craig
NOTARY PUBLIC

PETER BENJAMIN
LAKE COUNTY AUDITOR

KAREN CRAIG
Lake County
My Commission Expires
Nov. 04, 2006

COUNTY OF RESIDENCE:

THIS DOCUMENT PREPARED BY: PATRICK McMANAMA, ATTORNEY AT LAW ID9534-45

001284

11 CM

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.

Local No. 2399-01

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No. .....

127551

TYPE/PRINT IN PERMANENT BLACK INK

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

DECEDENT

1 DECEASED—NAME (First, Middle, Last)	2 SEX	3a TIME OF DEATH	3b DATE OF DEATH (Month, Day, Yr.)
STELLA C. OLSZEWSKI	FEMALE	2:15 P M	OCTOBER 24, 2001

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)
313-40-0491	81			APRIL 28,1920	HAMMOND, INDIANA

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)
NO	N/A	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
THE COMMUNITY HOSPITAL	MUNSTER	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
WIDOW	NONE	HOMEMAKER	OWN HOME

13a RESIDENCE—STATE	13b COUNTY	13c CITY, TOWN, OR LOCATION	13d STREET AND NUMBER
INDIANA	LAKE	HAMMOND	7749 CATALPA

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)	
46324	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	WHITE	Elementary/Secondary (0-12): 10th	College (1-4 or 5 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19 MOTHER'S NAME (First, Middle, Maiden Surname)
STANLEY ZIEMKIEWICZ	AGNES LEFKOWICZ

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
DIANE PIETERS	8536 CALUMET AVE., MUNSTER, INDIANA 46321	DAUGHTER

DISPOSITION

21a METHOD OF DISPOSITION	21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	OCTOBER 27, 2001 HOLY CROSS CEMETERY	CALUMET CITY, ILLINOIS

22a EMBALMER'S NAME	22b EMBALMER'S LICENSE NO.	23 WAS DEATH REPORTED TO CORONER?
DEAN G. WAGNER	8800057	☒ No ☐ Yes

24a SIGNATURE OF FUNERAL DIRECTOR	24b LICENSE NUMBER (of Licensee)	25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	1007231	SOLAN FUNERAL HOME FH83002893 7109 CALUMET AVE., HAMMOND, IN. 46324

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 Cerebrovascular accident	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b DUE TO (OR AS A CONSEQUENCE OF): Heat Stroke	
	c DUE TO (OR AS A CONSEQUENCE OF):	
	d DUE TO (OR AS A CONSEQUENCE OF):	

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)
Hypertension	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)
Conrado Pineline	01027402	10/25/01

30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): Conrado P. Castor, M.D. 911-A Fran-Lin Parkway Munster, IN 46321

HEALTH OFFICER

31 HEALTH OFFICER'S SIGNATURE: [signature] D.O.

32 DATE FILED (Month, Day, Year): October 26, 20

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.
	2