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Please Return To: ATTORNEY ARNOLD KREVITZ
500 East 86th Avenue, Merrillville, IN 46410

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA 2002 } 104946
COUNTY OF LAKE)

2002 NOV 15 11:13

FRANCES J. OSTROWSKI, a/k/a FRANCES OSTROWSKI, being first duly sworn upon her oath, deposes and says:

1. That she was married to RAYMOND J. OSTROWSKI, who died a resident of Gary, Lake County, Indiana, on March 26, 2002.

2. That at the time of his death, RAYMOND J. OSTROWSKI and FRANCES J. OSTROWSKI, a/k/a FRANCES OSTROWSKI, Husband and Wife, held title under a Quit-Claim Deed to the following-described Real Estate, to-wit:

Lots 45 and 46 in Block 2 in the Subdivision of the West 14.80 acres of Block No. 2 of Miller Station in the City of Gary, as per plat thereof recorded in Plat Book 4, page 17.

Commonly known as: 624 Dearborn Street, Gary, Indiana 46303
Key Number: 46-45-45
Unit 25

3. That the Affiant and the Decedent, RAYMOND J. OSTROWSKI, were Husband and Wife continuously from the time they acquired title to the above-described Real Estate to the time of his death on March 26, 2002.

4. That the Estate of decedent, RAYMOND J. OSTROWSKI, was not of sufficient value to be subject to Federal Estate Taxes or Indiana Inheritance Taxes.

FURTHER AFFIANT SAYETH NOT.

NOV 15 2002
Frances J. Ostrowski
FRANCES J. OSTROWSKI, PETER BENJAMIN
a/k/a FRANCES OSTROWSKI LAKE COUNTY AUDITOR

8th Subscribed and sworn to before me, a Notary Public, this day of NOVEMBER, 2002.

Arnold Krevitz
ARNOLD KREVITZ, Notary Public
Resident of LAKE County

My Commission Expires:
JAN. 24, 2009

This Instrument Prepared by: ARNOLD KREVITZ, Attorney At Law
500 East 86th Av., Merrillville, IN 46410

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not
21744

* 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

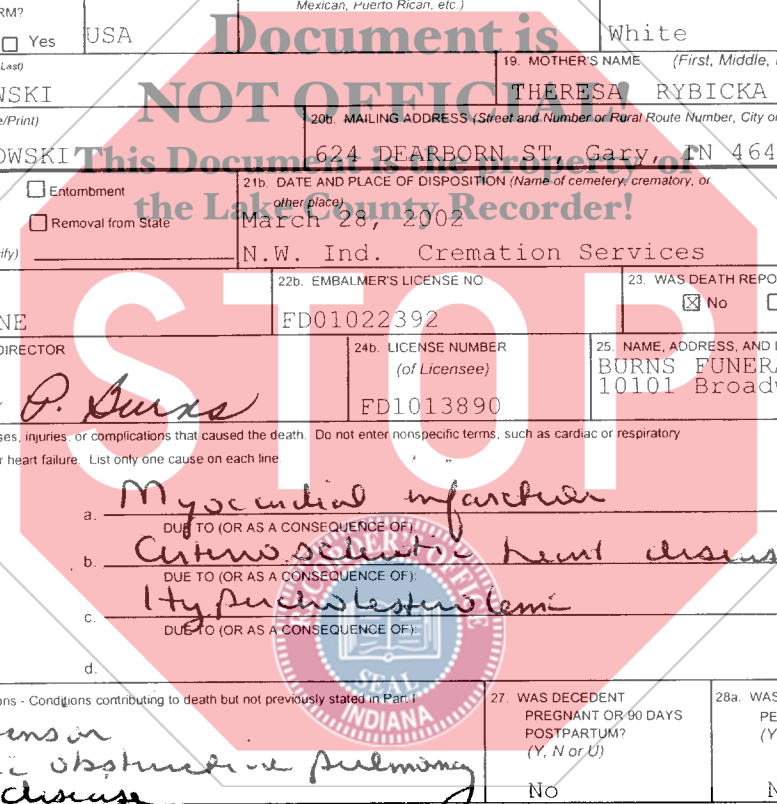
CERTIFICATE OF DEATH

Local No. 02 0225

State No.

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

TYPE/PRINT IN PERMANENT BLACK INK	1. DECEASED - NAME (First, Middle, Last) RAYMOND J OSTROWSKI			2. SEX Male	3a. TIME OF DEATH 9:55 AM	3b. DATE OF DEATH (Month, Day, Yr.) March 26, 2002	
	4. ★ SOCIAL SECURITY NUMBER 305-20-4006		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.) July 04, 1924	7. BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO Indiana
DECEDENT	8a. WAS DECEDENT A U.S. VETERAN? Yes	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? 1943	PLACE OF DEATH (Check only one. See instructions)				
	9b. FACILITY NAME (If not institution, give street and number) Methodist Hospital Northlake Campus		9c. CITY, TOWN, OR LOCATION OF DEATH Gary		9d. COUNTY OF DEATH Lake		
PARENTS INFORMANT	10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) FRANCES SPISAK	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) RETIRED BONDSMAN		12b. KIND OF BUSINESS/INDUSTRY AMERICAN BAIL BOND		
	13a. RESIDENCE - STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Gary		13d. STREET AND NUMBER 624 DEARBORN ST		
	13e. ZIP CODE 46403	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) 10 College (1-4 or 5+) N/A	
DISPOSITION	18. FATHER'S NAME (First, Middle, Last) FELIX OSTROWSKI			19. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA RYBICKA			
	20a. INFORMANT'S NAME (Type/Print) FRANCES OSTROWSKI			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 DEARBORN ST, Gary, IN 46403		20c. Relationship WIFE	
CAUSE OF DEATH	21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) March 28, 2002 N.W. Ind. Cremation Services		21c. LOCATION - City or Town, State Crown Point, Indiana		
	22a. EMBALMER'S NAME CRAIG B. MALONE		22b. EMBALMER'S LICENSE NO. FD01022392		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
	24a. SIGNATURE OF FUNERAL DIRECTOR <i>Release P. Burns</i>		24b. LICENSE NUMBER (of Licensee) FD1013890		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME BURNS FUNERAL HOME & FH83002445 10101 Broadway, Crown Point, Indiana 46307-8801		
HEALTH OFFICER	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						
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) b. Chronic obstructive heart disease DUE TO (OR AS A CONSEQUENCE OF) c. Hypertensive DUE TO (OR AS A CONSEQUENCE OF) d.					Approximate Interval Between Onset and Death Minutes Years Years	
	PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I Hypertension Chronic obstructive pulmonary disease						
	27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Y, N or U) 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) -		
CERTIFIER	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) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Kovacich</i>		29c. MEDICAL LICENSE NO. IN 103337	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28)(Type/Print) DR. MICHAEL KOVACICH 8777 Broadway, Merrillville, IN 46457			29d. DATE SIGNED (Month, Day, Year) NOV 15 2002			
HEALTH OFFICER	31. HEALTH OFFICER'S SIGNATURE <i>Michael Kovacich</i>						
	33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <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) March 26, 2002			34h. MOTOR VEHICLE ACCIDENT? (Yes or No) If yes, specify driver, passenger, pedestrian, etc. 001252				



FILED

APR 02 2002