

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2

2003 073068

2003 JUL 15 2:17 PM '03

2193LK03

AFFIDAVIT OF SURVIVORSHIP

HOLD FOR MERIDIAN TITLE CORP

Vincent J. Seida Sr. , of adult age, being first duly sworn, upon deposes and says:

That, Vincent J. Seida Sr. is the husband of Patricia C Seida , deceased, who died on May 25, 2001 a resident of Lake County,.

That affiant and said decedent, as husband and wife acquired title to the following described real estate located in Lake County, Indiana, to wit:

Lot 12 in Sun Meadows Unit 1, an Addition to the Town of St. John, as per plat thereof, recorded in Plat Book 67, page 27 and amended by Plat of Correction recorded in Plat Book 67, page 57, and further amended by Plat of Correction recorded in Plat Book 70, page 10, in the Office of the Recorder of Lake County, Indiana., and as corrected by Certificate recorded January 8, 1998 as Document No. 878392 and re-recorded March 8, 1998 as Document No. 088015 and further re-recorded July 27, 1990 as Document No. 113888.

and hereinafter sometimes called "the Real Estate" for convenience by a Deed from recorded as Document Number in the Office of the Recorder of Lake County, Indiana.

That affiant and said decedent were legally married to one another at this time and that said marital relationship between them continued unbroken by divorce, dissolution or annulment of marriage, until the death of said decedent on the date hereinabove indicated.

That said decedent (left no will) (left a will in which no attempt was made to dispose of any interest in the Real Estate except to said surviving spouse).

That affiant (knows) (is informed and believes) that the total value of the gross estate of said decedent for federal estate taxes does not equal or exceed the exemption equivalent applicable under federal law, and so, no federal estate tax could be, or is, due.

And further affiant sayeth not.

Vincent J. Seida Sr.

Vincent J. Seida Sr.

State of In, County of Lake ss:

Subscribed and sworn to before me, the undersigned, a Notary Public in and for the County and State aforesaid, this 3rd day of July, 2003

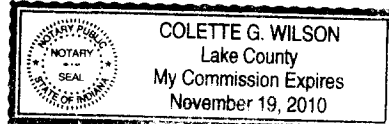
WITNESS my hand and Notarial Seal.

My Commission Expires: _____

Colette G. Wilson

Signature of Notary Public

Printed Name of Notary Public



Notary Public County and State of Residence

This instrument was prepared by: Frank A. Antonovitz, Attorney-at-Law #2437-98
202 S. Michigan St., Ste. 1000, South Bend, IN 46601
2193LK03 cr

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

JUL 15 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

001002

11.00
ZP
MT

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

State No.

Local No. 1201-01

793757

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Patricia C. Seida		2. SEX Female		3a. TIME OF DEATH 8:15A M		3b. DATE OF DEATH (Month, Day, Yr.) May 25, 2001	
4. *SOCIAL SECURITY NUMBER 350-20-5004		5a. AGE—Last Birthday (Years) 72		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr.) Aug. 24, 1928		7. BIRTHPLACE (City and State or Foreign Country) Chicago, IL					
8a. WAS DECEDENT A U.S. VETERAN? No		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None		9a. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) 8651 Primrose Dr.				9c. CITY, TOWN, OR LOCATION OF DEATH St. John		9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married		11. SURVIVING SPOUSE (If wife, give maiden name) Vincent Seida		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Registered Nurse		12b. KIND OF BUSINESS/INDUSTRY Medical	
13a. RESIDENCE—STATE IN		13b. COUNTY Lake		13c. CITY, TOWN, OR LOCATION St. John		13d. STREET AND NUMBER 8651 Primrose Dr.	
13e. ZIP CODE 46371		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? U.S.A.		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+): 3					
18. FATHER'S NAME (First, Middle, Last) James Lane				19. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Ivins			
20a. INFORMANT'S NAME (Type/Print) Vincent Seida, Sr.				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8651 Primrose Dr. St. John, IN 46371		20c. Relationship Husband	
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Entombment <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) May 29, 2001 Queen of Heaven			21c. LOCATION—City or Town, State Hillside, IL		
22a. EMBALMER'S NAME Thomas J. Burns		22b. EMBALMER'S LICENSE NO. 1045184		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Thomas J. Burns</i>		24b. LICENSE NUMBER (of Licensee) 1045184		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN (For Hennessey-Bruno F.H./Berkley, IL Signature Only)			
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. <i>Infarct due to congestive heart failure</i> Approximate Interval Between Onset and Death months b. <i>Ischemic cardiomyopathy</i> years c. <i>Coronary artery disease</i> years d. <i>Atherosclerosis</i> years PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I <i>Valvular heart disease</i> <i>atrial fibrillation</i> <i>Diabetes</i>							
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) ---			
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 A. Nicholas</i>				29c. MEDICAL LICENSE NO. <i>02000901</i>		29d. DATE SIGNED (Month, Day, Year) May 25, 2001	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Michael Nicholas 24 Joliet Dyer, IN 46311							
31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Best, D.O.</i>				32. DATE FILED (Month, Day, Year) <i>May 31, 2001</i>			
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)		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.			