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LAKE COUNTY
FILED FOR RECORD

2003 076319

2003 JUL 22 10:45 AM

Chicago Title Insurance Company

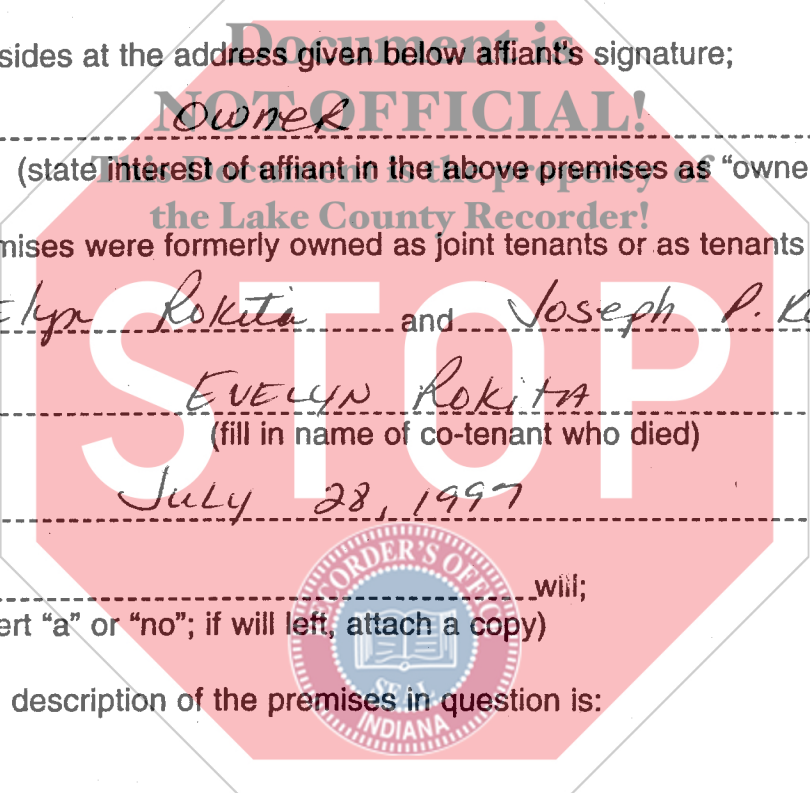
SURVIVORSHIP AFFIDAVIT

620035921

On this July 16, 2003 before me personally appeared Joseph P. Rokita
(insert date)

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

- Affiant resides at the address given below affiant's signature;
- Affiant is owner
(state interest of affiant in the above premises as "owner", "son of owner", etc.)
- Said premises were formerly owned as joint tenants or as tenants by the entireties by Evelyn Rokita and Joseph P. Rokita;
- Said Evelyn Rokita
(fill in name of co-tenant who died)
died on July 28, 1997
leaving _____ will;
(insert "a" or "no"; if will left, attach a copy)
- The legal description of the premises in question is:



CHICAGO TITLE INSURANCE COMPANY

6. Is there Federal Estate or State inheritance tax liability by reason of the death of said decedent? Yes No

If yes, then estimated taxes due are \$ _____

The taxes due are paid or unpaid.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

JUL 22 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

15
cc
ST

001508

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced?

----- no -----

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

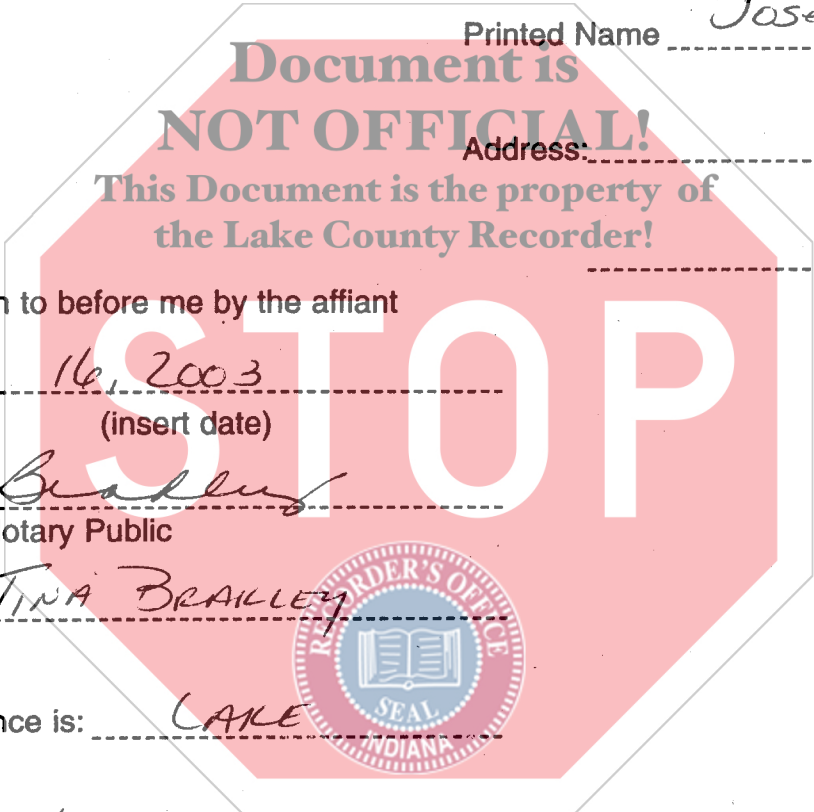
-----) ;

8. Affiant's relationship to the deceased was -----

Signature: x Joseph Rokita

Printed Name Joseph P. Rokita

Address: -----



Subscribed and sworn to before me by the affiant

this July 16, 2003
(insert date)

Tina Brakley
Notary Public

Printed Name TINA BRAKLEY

My County of Residence is: LAKE

In the State of INDIANA

My Commission Expires -----

This instrument prepared by Joseph P. Rokita

TINA BRAKLEY
Notary Public, State of Indiana
County of Lake
My Commission Expires Dec 26, 2007

* 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. 1573-97

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

200804
TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) EVELYN ROKITA		2. SEX FEMALE		3a. TIME OF DEATH 10:30 A		3b. DATE OF DEATH (Month, Day, Yr) JULY 28, 1997	
4. *SOCIAL SECURITY NUMBER 342-14-4475		5a. AGE—Last Birthday (Years) 74		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr) JULY 5, 1923		7. BIRTHPLACE (City and State or Foreign Country) ILLINOIS					
8a. WAS DECEASED 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) 8620 LEE ST.			9c. CITY, TOWN, OR LOCATION OF DEATH CROWN POINT			9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS MARRIED		11. SURVIVING SPOUSE (Specify) JOSEPH ROKITA		12a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b. KIND OF BUSINESS/INDUSTRY DOMESTIC	
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION CROWN POINT		13d. STREET AND NUMBER 8620 LEE ST.	
13a. ZIP CODE 46307		13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. WAS DECEASED OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	
13g. ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		16. RACE—American Indian, Black, White, etc. (Specify) WHITE		17. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> 12 College (1-4 or 5+) <input type="checkbox"/>			
18. FATHER'S NAME (First, Middle, Last) JOSEPH ZORICH				19. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA			
20a. INFORMANT'S NAME (Type/Print) JOSEPH ROKITA			20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8620 LEE ST. CROWN POINT, IND. 46307			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) AUGUST 1, 1997 HOLY CROSS CEMETERY			21c. LOCATION—City or Town, State CALUMET CITY, ILLINOIS		
22a. EMBALMER'S NAME CHARLES WELLS		22b. EMBALMER'S LICENSE NO. FD01042372		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>E. Lyko</i>		24b. LICENSE NUMBER (of Licensee) FD01008300		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LINCOLN RIDGE FUNERAL HOME 88800070 7607 W. LINCOLN HWY. CROWN POINT, IN. 46307			
26. PART I. Enter the disease, 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 completed cause of death) <i>Hypertensive heart disease. Coronaries</i>							
DEATH DUE TO (OR AS A CONSEQUENCE OF) <i>arteries disease.</i>							
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 DECEASED 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)			
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>Nazgul Obaid</i> M.D. NAZZAL OBAID			29c. MEDICAL LICENSE NO. 01028410			29d. DATE SIGNED (Month, Day, Year) 07-30-97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If not, Print "None") 8895 PROSPECT AVE, ARLINGTON, IN 46410							
31. HEALTH OFFICER'S SIGNATURE <i>Alexander</i>						32. DATE FILED (Month, Day, Year) July 31, 1997	
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.			

LEGAL DESCRIPTION

Lot 41, in Block 2, in Schererville Heights, Section No. 1, as per plat thereof, recorded in Plat Book 33 page 39, in the Office of the Recorder of Lake County, Indiana.

