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STATE OF INDIANA
COUNTY OF LAKE

2003 105906

) SS:
)

2003 OCT 2 10:00

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AFFIDAVIT OF SURVIVORSHIP

Comes now Robert J. Kish, being duly sworn upon his oath and states as follows:

1. That he is the son of Lewis Kish and Anna Kish owners in fee simple of the following real estate located in Lake County, Indiana, more particularly described as follows:

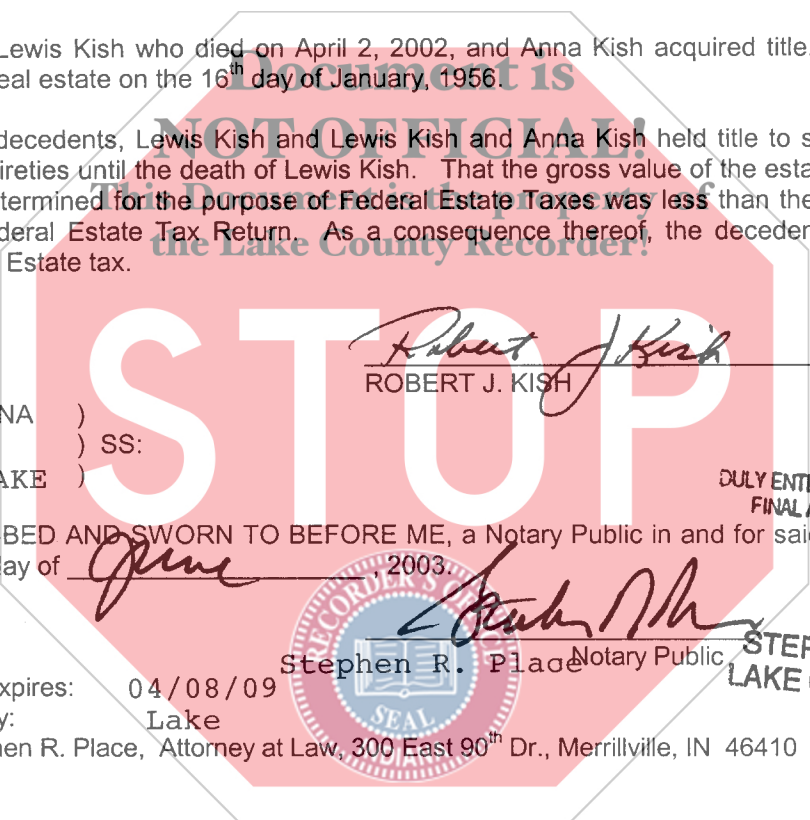
THE WEST SIXTEEN (16) FEET OF LOT TWENTY-ONE (21), ALL OF LOT TWENTY TWO (22), AND THE EAST ELEVEN (11) FEET OF LOT TWENTY-THREE (23), IN BLOCK EIGHT (8), IN EASTOVER ADDITION TO THE CITY OF GARY, LAKE COUNTY, INDIANA AS RECORDED IN BOOK 1019, PAGE 525 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA, MORE COMMONLY KNOWN AS:

1106 East 41st Avenue
Gary, Indiana 46409

And that Lewis Kish who died on April 2, 2002, and Anna Kish acquired title, as tenants by the entireties to said real estate on the 16th day of January, 1956.

That the decedents, Lewis Kish and Lewis Kish and Anna Kish held title to said real estate as tenants by the entireties until the death of Lewis Kish. That the gross value of the estate of the decedent, Lewis Kish, as determined for the purpose of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return. As a consequence thereof, the decedent's estate was not subject to Federal Estate tax.

CHICAGO TITLE INSURANCE COMPANY



Robert J. Kish
ROBERT J. KISH

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

DULY ENTERED FOR TAXATION SUBJECT TO
FINAL ACCEPTANCE FOR TRANSFER

SUBSCRIBED AND SWORN TO BEFORE ME, a Notary Public in and for said County and State
this 27 day of June, 2003.

Stephen R. Place
Stephen R. Place Notary Public

OCT 2 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

My Commission Expires: 04/08/09
Resident of County: Lake
Prepared by Stephen R. Place, Attorney at Law, 300 East 90th Dr., Merrillville, IN 46410

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GT-DG

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. 515-02

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER I.C. 16-2-1

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) LEWIS KISH		2 SEX MALE		3a TIME OF DEATH 4:55 P		3b DATE OF DEATH (Month Day Year) APRIL 2, 2002	
4 *SOCIAL SECURITY NUMBER 306-09-1484		5a AGE—Last Birthday (Years) 90		5b UNDER YEAR Months Days		6 DATE OF BIRTH (Mo Day Yr) JANUARY 4, 1912	
8a WAS DECEDENT A U.S. VETERAN? NO		8b YEAR LAST SERVED IN U.S. ARMED FORCES? -----		9a PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> ER Outpatient <input type="checkbox"/> POA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
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) ANNA KOVAL		12a DECEASED'S USUAL OCCUPATION (Give kind of work showing most of working life. Do not use retired) BUS DRIVER		12b KIND OF BUSINESS/INDUSTRY GARY TRANSIT SYSTEM	
13a RESIDENCE—STATE INDIANA		13b COUNTY LAKE		13c CITY/TOWN OR LOCATION GARY		13d STREET AND NUMBER 1106 E. 41ST AVENUE	
13e ZIP CODE 46409		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) 9 College (1-4 or 5+)					
18 FATHER'S NAME (First Middle Last) LEWIS KISH				19 MOTHER'S NAME (First Middle Maiden Surname) HELEN			
20a INFORMANT'S NAME (Type/Print) ANNA KISH				20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) 1106 E. 41ST AVE., GARY, INDIANA 46409		20c Relationship WIFE	
21a METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify) _____		21b DATE AND PLACE OF DISPOSITION (Name of cemetery crematory or other place) APRIL 6, 2002 CALUMET PARK CEMETERY		21c LOCATION—City or Town State MERRILLVILLE, INDIAN.			
22a EMBALMER'S NAME JONATHON R. CHRISTIANSEN		22b EMBALMER'S LICENSE NO. FI20100045		23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
24a SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b LICENSE NUMBER (of Licensee) FD01009893		25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH83002 PRUZIN BROTHERS FUNERAL SERVICE 6360 BROADWAY, MERRILLVILLE, IN 464			
26 PART I Enter the diseases, injuries or complications that caused the death (Do not write answers in terms such as cardiac or respiratory arrest shock or heart failure. List only one cause for each line.) ASPIRATION PNEUMONIA		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
IMMEDIATE CAUSE (Final disease or condition resulting in death) a _____ b _____ c _____ d _____		PART II Other significant conditions—Conditions contributing to death but not previously stated in Part I					
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>[Signature]</i>		29c MEDICAL LICENSE NO. 01037515		29d DATE SIGNED (Month Day Year) 4-24-02	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) MILTON GASPARIS, MD 1400 SOUTH LAKE PARK AVE., HOBART, IN 46342							
31 HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				32 DATE FILED (Month Day Year) April 9, 2002			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		34a DATE OF INJURY (Month Day Year)		34b PLACE OF INJURY—At home farm street factory office building etc (Specify)		34c LOCATION (Street and Number or Rural Route Number City or Town State)	
34d DESCRIBE HOW INJURY OCCURRED		34g DATE PRONOUNCED DEAD (Month Day Year)					
34h MOTOR VEHICLE ACCIDENT? (Yes or no. If yes specify driver passenger pedestrian etc)							

