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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2003 107816 2003 OCT -9 AM 9:03

MORRIS W. CARTER
RECORDER

TICOR TITLE INSURANCE

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

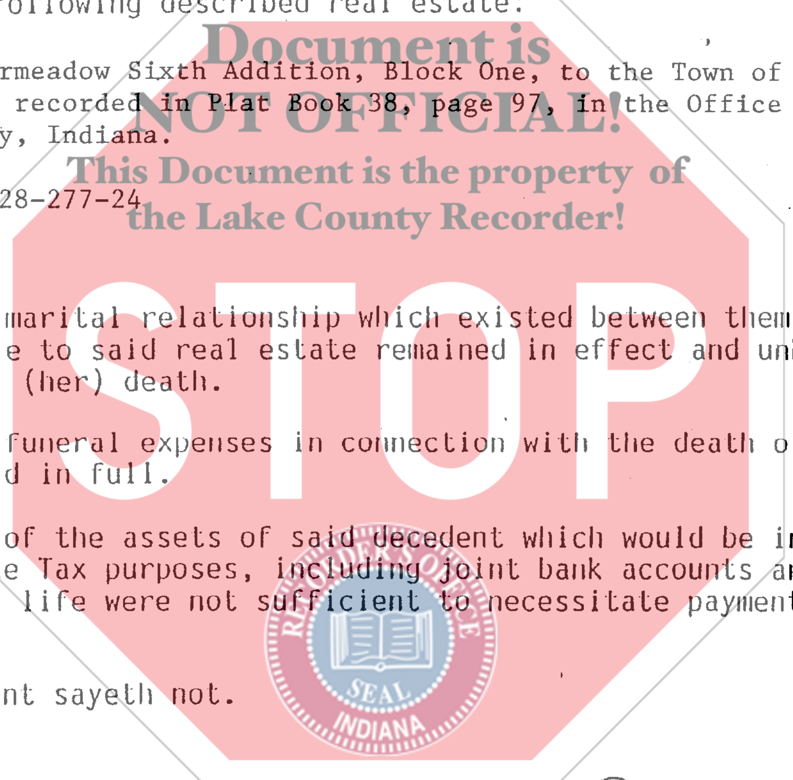
Donna J. Magdziarz, being first duly sworn upon oath, deposes and says:

1. That Michael Magdziarz died on January 9, ~~19~~ 2002 at Hammond, Indiana.

2. That Michael Magdziarz and Donna J. Magdziarz were duly and legally married at the time they acquired title as husband and wife to the following described real estate:

Lot 24 in Fairmeadow Sixth Addition, Block One, to the Town of Munster, as per plat thereof, recorded in Plat Book 38, page 97, in the Office of the Recorder of Lake County, Indiana.

Key No. (18) 28-277-24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3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of (his) (her) death.

4. That all funeral expenses in connection with the death of said decedent have been paid in full.

5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

x Donna Magdziarz

OCT 7 2003

STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

Subscribed and sworn to before me, a Notary Public, this ______ day of September, 19 2003.

Shannon Stiener
Notary Public
Shannon Stiener

My Commission expires:
3/14/07

County of Residence:
Lake

000568

This Instrument prepared by Donna Magsziarz

SOUTHSHORE TITLE LLC
11055 BROADWAY
CROWN POINT, IN 46307

99003150
SOUTHSHORE TITLE LLC

12. SS DC

* 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

THIS CERTIFIES THE FOLLOWING IS A TRUE AND COMPLETE COPY OF DEATH ON FILE WITH THE HAMMOND HEALTH DEPARTMENT.

Sept. 25 2003 — Date Issued — [signature] Hammond Health Commissioner

Local No. [illegible] 43

RESUBMIT

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First, Middle, Last): MICHAEL MAGDZIARZ
2. SEX: MALE
3a. TIME OF DEATH: 6:57 P M
3b. DATE OF DEATH (Month, Day, Yr.): JANUARY 9, 2002
4. *SOCIAL SECURITY NUMBER: 355-42-4056
5a. AGE—Last Birthday (Years): 51
5b. UNDER 1 YEAR (Months / Days):
5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Mo, Day, Yr): MAY 10, 1950
7. BIRTHPLACE (City and State or Foreign Country): HAMMOND, INDIANA
8a. WAS DECEDENT A U.S. VETERAN?: NO
8b. YEAR LAST SERVED IN U.S. ARMED FORCES?: N/A
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution, give street and number): ST. MARGARET MERCY HOSPITAL
9c. CITY, TOWN, OR LOCATION OF DEATH: HAMMOND
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): MARRIED
11. SURVIVING SPOUSE (If wife, give maiden name): DONNA TRGOVICH
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): FIREFIGHTER
12b. KIND OF BUSINESS/INDUSTRY: CITY OF HAMMOND
13a. RESIDENCE—STATE: INDIANA
13b. COUNTY: LAKE
13c. CITY, TOWN, OR LOCATION: SCHERERVILLE
13d. STREET AND NUMBER: 2704 CAPRI DRIVE
13e. ZIP CODE: 46375
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: U.S.A.
15. WAS DECEDENT OF HISPANIC ORIGIN?: ☒ No ☐ 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): — College (1-4 or 5+): 4

PARENTS

18. FATHER'S NAME (First, Middle, Last): RAYMOND MAGDZIARZ
19. MOTHER'S NAME (First, Middle, Maiden Surname): VIRGINIA PALIGA

INFORMANT

20a. INFORMANT'S NAME (Type/Print): DONNA MAGDZIARZ
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2704 CAPRI DRIVE, SCHERERVILLE, IN 46375
20c. Relationship: WIFE

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Entombment ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): JANUARY 11, 2002 CHAPEL LAWN MEMORIAL GARDENS
21c. LOCATION—City or Town, State: SCHERERVILLE, INDIANA
22a. EMBALMER'S NAME: KEITH D. ANTHONY
22b. EMBALMER'S LICENSE NO.: 01011911
23. WAS DEATH REPORTED TO CORONER?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature] Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH83002835 4404 CAMERON, HAMMOND, INDIANA 46327

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. RESPIRATORY ARREST.	UNKNOWN
	DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO INADVERTENT INFUSION OF MEDICATION.	
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	DUE TO (OR AS A CONSEQUENCE OF): c. THROMBOEMBOLI IN BOTH LUNGS.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.: THERAPEUTIC MISADVENTURE.
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): NO
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): YES
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no): YES

CERTIFIER

29a. CERTIFIER (Check only one): DEPUTY
☐ 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: [signature]
29c. MEDICAL LICENSE NO.: N/A
29d. DATE SIGNED (Month, Day, Year): FEBRUARY 25, 2002
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): DONNA MELYON, DEPUTY CORONER, 2900 WEST 93RD AVENUE, CROWN POINT, INDIANA 46307

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] Franklin D. Bermudez M.D.
32. DATE FILED (Month, Day, Year): February 28, 2002

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☒ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year): JAN. 7, 2002
34b. TIME OF INJURY: UNKNOWN
34c. INJURY AT WORK? (Yes or no): NO
34d. DESCRIBE HOW INJURY OCCURRED: INFUSION OF MEDICATION
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify): HOSPITAL
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 5454 HOHMAN AVENUE HAMMOND, INDIANA
34g. DATE PRONOUNCED DEAD (Month, Day, Year): JANUARY 9, 2002
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.: NO.

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RECORDER'S OFFICE SEAL LAKE COUNTY INDIANA

SDH06-004 State Form 10110 (R5/1-99)