

3 ORIGINAL

1st

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA ) RE: Sophie D. Kolodziej, Deceased March 3, 2000
) SS Legal: Lot 25, Block G, in Meadowlands Manor,
COUNTY OF LAKE ) Unit #2, in the Town of Merrillville, as per plat
Thereof, recorded in Plat Book 31, Page 97,
Lake County, Indiana 36-15-310-26

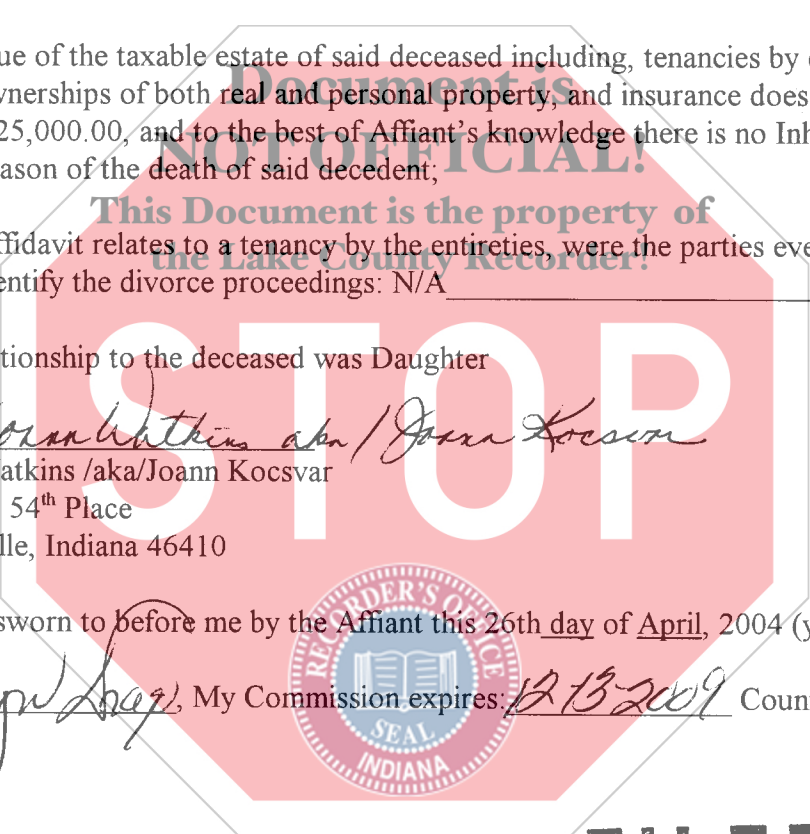
On this 26th day of April, 2004 before me personally appeared Joann Watkins identified to me State of Indiana Driver License, who being duly sworn on oath did say that:

- 1. Affiant resides at the address given below Affiant's signature:
2. Affiant is Heir at Law, Daughter of Deceased, Sophie D. Kolodziej owner(s), (Interest of Affiant in the above premises as "owner" "heir of owner" etc.
3. Said premises were formerly owned by Sophie D. Kolodziej and Joann Kocsvar a/k/a Joann Watkins.
4. Said Sophie D. Kolodziej, Deceased March 3, 2000, intestate, in Lake County, Indiana
5. The total value of the taxable estate of said deceased including, tenancies by entireties individual ownerships of both real and personal property, and insurance does not exceed the sum of \$25,000.00, and to the best of Affiant's knowledge there is no Inheritance tax liability by reason of the death of said decedent;
6. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? No (if yes identify the divorce proceedings: N/A
7. Affiant's relationship to the deceased was Daughter

Signature Joann Watkins aka / Joann Kocsvar
Joann Watkins /aka/Joann Kocsvar
627 East 54th Place
Merrillville, Indiana 46410

Subscribed and sworn to before me by the Affiant this 26th day of April, 2004 (year)

Notary [Signature] My Commission expires: 12-13-2009 County of Lake



2004 037999

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

FILED

000818

MAY 7 2004

STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

14 DG 3973 HELP mtc

STATE OF INDIANA        )        In Re: Sophie D. Kolodziej, deceased March 3, 2000  
                                  )        SS :  
COUNTY OF LAKE        )

Affidavit For Transfer of Real Property

1. That the above named decedent died intestate on date.
2. That forty-five (45) days have elapsed since the death of decedent.
3. That no application or petition for the appointment of personal representation is pending or has been granted in any jurisdiction, nor is any administration contemplated.
4. That the following named person is the legal heir of decedent: Joann Watkins, daughter, of 627 East 47<sup>th</sup> Place, Merrillville, Indiana 46410.
5. That the value of the decedent's estate does not exceed the sum of the allowance provided by IC 29-8:1 and reasonable funeral expenses.
6. That the decedent's assets is a parcel or real estate which was owned by the decedent, located at 627 East 54<sup>th</sup> Place, Merrillville, Indiana 46410, described as following:  

Lot 25, Block G, in Meadowlands Manor, Unit #2, in the Town of Merrillville, as per plat thereof, recorded in Plat Book 31, Page 97, in the Office of the Recorder of Lake County, Indiana. Tax Unit 36 Key Number 15-310-25.
7. That the following list of persons, firms, or corporations are the only creditors of the estate and the amount set opposite each name is the sum due said creditor so far as the same is: NONE
8. That the individuals entitled to real estate as a result of the decedent's death is the heir at law provided under the laws of intestate.
9. That the gross value of estate of decedent, Sophie D. Kolodziej as determined for purposes of Federal Estate Taxes was less than the value required for the filing of a Federal Estate Tax Return. As consequence thereof, the decedent's estate was not subject to Federal Estate Tax.
10. That the decedent's estate was not subject to Indiana Inheritance Tax.

EXHIBIT A

ATTENTION ESTATE: The Social Security # is requested by this state agency in order to sue 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. 0637-00

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

PE/PRINT IN PERMANENT BLACK INK

DECEDENT

MENTS

FORMANT

POSITION

USE OF THIS

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First Middle Last) <b>SOPHIE D. KOLODZIEJ</b>		2 SEX <b>FEMALE</b>	3a TIME OF DEATH <b>10:27P M</b>	3b DATE OF DEATH (Month Day Year) <b>MARCH 3, 2000</b>
4 *SOCIAL SECURITY NUMBER <b>311-12-3085D</b>	5a AGE—Last Birthday (Years) <b>79</b>	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo Day Yr) <b>April 4, 1920</b>
7 BIRTHPLACE (City and State or Foreign Country) <b>East Chicago, Indiana</b>	8a WAS DECEDENT A U.S. VETERAN? <b>NO</b>	8b YEAR LAST SERVED IN U.S. ARMED FORCES? <b>-</b>	9a PLACE OF DEATH (Check only one See instructions) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 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) <b>Methodist Hospital-Southlake Campus</b>	9c CITY TOWN OR LOCATION OF DEATH <b>Merrillville</b>	9d COUNTY OF DEATH <b>Lake</b>	10 MARRITAL STATUS (Specify) <b>Widowed</b>	
11 SURVIVING SPOUSE (If wife give maiden name) <b>-</b>	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life Do not use retired) <b>Homemaker</b>	12b KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	13a RESIDENCE—STATE <b>Indiana</b>	
13b COUNTY <b>Lake</b>	13c CITY TOWN OR LOCATION <b>Merrillville</b>	13d STREET AND NUMBER <b>5415 Carolina St.</b>	13e ZIP CODE <b>46410</b>	
13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	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) <b>White</b>	17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>
18 FATHER'S NAME (First Middle Last) <b>Stanley Kotas</b>	19 MOTHER'S NAME (First Middle Maiden Surname) <b>Agatha N/A</b>			
20a INFORMANT'S NAME (Type/Print) <b>Joann Watkins</b>	20b MAILING ADDRESS (Street and Number or Rural Route Number City or Town State Zip Code) <b>627 E. 54th. Pl. Merrillville, IN 46410</b>	20c Relationship <b>Daughter</b>		
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) <b>March 7, 2000 Holy Cross Cemetery</b>	21c LOCATION—City or Town State <b>Calumet City, Illinois</b>		
22a EMBALMERS NAME <b>Leonard Gregorczyk</b>	22b EMBALMERS LICENSE NO. <b>FD08800305</b>	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR <i>Leonard Gregorczyk</i>	24b LICENSE NUMBER (of Licensee) <b>FD08800305</b>	25 NAME ADDRESS AND LICENSE NUMBER OF FUNERAL HOME <b>STILINOVICH &amp; WIATROLIK FH8300445 7535 Taft St. Merrillville, IN 46410</b>		
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 <b>Septic Shock</b> DUE TO (OR AS A CONSEQUENCE OF)		<b>2 d</b>		
b <b>Large cell Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF)		<b>1 mo.</b>		
c _____ DUE TO (OR AS A CONSEQUENCE OF)		_____		
d _____ DUE TO (OR AS A CONSEQUENCE OF)		_____		
PART II: Other significant conditions - Conditions contributing to death but not previously stated in Part I		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) <b>MAY 7 2004</b> <b>NO</b>		
		28a WAS AN AUTOPSY PERFORMED? (Yes or no) <b>NO</b>		28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <b>NO</b>
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.		STEPHEN R. STIGLICH LAKE COUNTY AUDITOR		
29b SIGNATURE AND TITLE OF CERTIFIER <i>Stephen R. Stiglich</i>		29c MEDICAL LICENSE NO. <b>01045710</b>	29d DATE SIGNED (Month Day Year) <b>3/8/00</b>	
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>M. Trybula, M.D. 125 East 89th. Ave. Merrillville, IN 46410</b>		THIS CERTIFIES THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE DEPARTMENT OF HEALTH <b>MARCH 14, 2000</b>		
31 HEALTH OFFICER'S SIGNATURE <i>Alexander S. Williams MD</i>	32 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	33a DATE OF INJURY (Month Day Year)	33b TIME OF INJURY	33c INJURY AT WORK? (Yes or no)
		33d DESCRIBE HOW INJURY OCCURRED <b>APR 28 2004</b>	34a PLACE OF INJURY—At home farm street factory office building etc. (Specify) <b>00063</b>	
34b LOCATION (Street and Number or Rural Route Number City or Town State)		34c DATE PRONOUNCED DEAD (Month Day Year)		
34d MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver passenger pedestrian etc				