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COMMUNITY TITLE COMPANY
— An Indiana Corporation —
421 West 81st Avenue
Merrillville, Indiana 46410
219-736-2810

2004 043562

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Harry Matasar, being first duly sworn upon oath, deposes and says:

1. That Affiant's spouse, Jeanne R. Matasar died (without leaving a will) (leaving a will) on August 11, 2003 at Community Hospital, MUNSTER INDIANA

2. That they were duly and legally married at the time they acquired title as husband and wife to the following described real estate:
Lot 10, FAIRMEADOW NINTH Addition, BLOCK 3, TO THE TOWN OF MUNSTER, LAKE COUNTY, INDIANA, AS SHOWN IN PLAT BOOK 37, PAGE 96, IN LAKE COUNTY, INDIANA

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.

COMMUNITY TITLE COMPANY
FILE NO L 28588

Harry Matasar

Subscribed and sworn to before me, a Notary Public, this 14th day of May, 2004.

Susan Lipton Hutti
Notary Public

My Commission expires:
11-13-2009

County of Residence:
Lake

FILED
MAY 25 2004
STEPHEN R. STIGLICH
LAKE COUNTY AUDITOR

This Instrument prepared by Patrick J. McManama, Attorney at Law
ID. NO. 9534-45

002065

12 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

State No. .....

Local No. 1914-03 86322

TYPE/PRINT IN PERMANENT BLACK INK

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

DECEDENT

1. DECEASED—NAME (First, Middle, Last): Jeanne Matasar	2. SEX: Female	3a. TIME OF DEATH: 4:22P M	3b. DATE OF DEATH (Month, Day, Yr.): August 11, 2003	
4. SOCIAL SECURITY NUMBER: 404-44-0732	5a. AGE—Last Birthday (Years): 71	5b. UNDER 1 YEAR: Months / Days	5c. UNDER 1 DAY: Hours / Minutes	6. DATE OF BIRTH (Mo. Day. Yr.): Feb. 7, 1932
7. BIRTHPLACE (City and State or Foreign Country): Louisville, KY				
8a. WAS DECEDENT A U.S. VETERAN? No	8b. YEAR LAST SERVED IN U.S. ARMED FORCES? None	8c. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL: XX Inpatient; ☐ ER/Outpatient; ☐ DOA	OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence	
9b. FACILITY NAME (If not institution, give street and number): Community Hospital	9c. CITY, TOWN, OR LOCATION OF DEATH: Munster	9d. COUNTY OF DEATH: Lake		
10. MARITAL STATUS (Specify): Married	11. SURVIVING SPOUSE (If wife, give maiden name): Harry Matasar	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Tax Preparer	12b. KIND OF BUSINESS/INDUSTRY: Accounting	
13a. RESIDENCE—STATE: IN	13b. COUNTY: Lake	13c. CITY, TOWN, OR LOCATION: Munster	13d. STREET AND NUMBER: 1405 Magnolia Lane	
13e. ZIP CODE: 46321	13f. INSIDE CITY LIMITS? ☐ No XX Yes	13g. ON A FARM? XX No ☐ Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	15. WAS DECEDENT OF HISPANIC ORIGIN? XX 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): 12	College (1-4 or 5+): 1		

PARENTS

18. FATHER'S NAME (First, Middle, Last): David Brill	19. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Weinberger

INFORMANT

20a. INFORMANT'S NAME (Type/Print): Harry Matasar	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1405 Magnolia Ln Munster, IN 46321	20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other (Specify)	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): August 12, 2003 Kneseth Israel Cemetery	21c. LOCATION—City or Town, State: Hammond, IN
22a. EMBALMER'S NAME: ----	22b. EMBALMER'S LICENSE NO.: ---	23. WAS DEATH REPORTED TO CORONER? XX No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: [signature]	24b. LICENSE NUMBER (of Licensee): 1021590	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: Burns-Kish Funeral Home #3004968 8415 Calumet Munster, IN 46321

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter mechanistic terms, such as cardiac arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Acute Renal Failure

DUE TO (OR AS A CONSEQUENCE OF): b. Complications

DUE TO (OR AS A CONSEQUENCE OF): c. ---

DUE TO (OR AS A CONSEQUENCE OF): d. ---

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last.

THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT. AUG 12 2003

Approximate Interval Between Onset and Death: 2 days 2 hours

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): 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): ---

CERTIFIER

29a. CERTIFIER (Check only one):
☒ 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.

29a. SIGNATURE AND TITLE OF CERTIFIER: X [signature]	29c. MEDICAL LICENSE NO.: 01044256	29d. DATE SIGNED (Month, Day, Year): Aug. 12, 2003

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): K. Raiker, M.D. 9038 Columbia Ave. Munster, IN 46321

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Susan W Burt D.O.

32. DATE FILED (Month, Day, Year): Aug 12 2003

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ 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.