

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

80378

On this 20th Day of September before me personally appeared John A. Freyek

Chicago Title Insurance Company

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

- 1. Affiant resides at the address given below affiant's signature:
2. Affiant is Son of Owner
3. Said premises were formerly owned as joint tenants or as tenants by the entirety by Frances Freyek (retaining a life estate), Joan F. McGill and John A. Freyek;
4. Said Frances Freyek died on May 22, 2004 leaving no will;
5. The legal description of the premises in question is:

Lot 16, except 20 feet by parallel lines off the entire north side thereof and of block 17 block 9 in Douglas Park Manor, Hammond, as per plat thereof recorded in plat book 17 page 26, in the office of the Recorder of Lake County, Indiana.

- 6. Is there Federal 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..

- 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 son.

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

SEP 29 2004

STEPHEN R. STIGLICH LAKE COUNTY AUDITOR

Signature: John A Freyek

Printed Name: John A. Freyek

Address: 3501 44th Street Highland, IN 46322

Subscribed and sworn to before me by the affiant

This 20th Day of September, 2004

Notary Public signature

Printed Name: Monique L. Stevens

My County of Residence is: Lake

In the State of Indiana

My Commission Expires 04/03/2010



CTIC Has made an accomodation recording of the instrument.

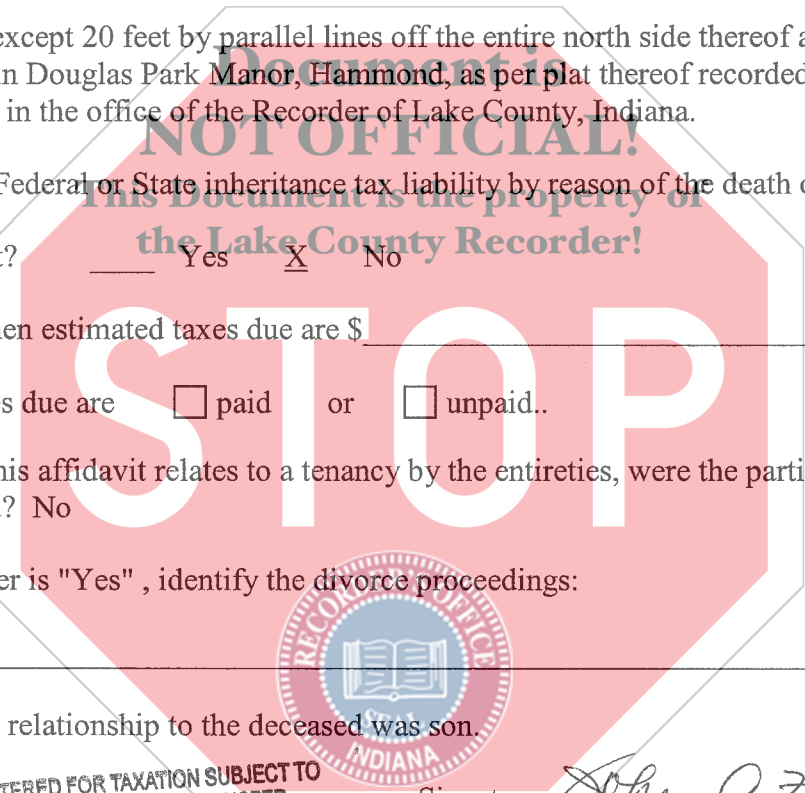
This instrument prepared by John A. Freyek

002307

Handwritten initials and numbers: 12 DC ET

2004 084303

STATE OF INDIANA LAKE COUNTY RECORDED FOR RECORD 2004 SEP 30 AM 9:34



\* 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.

Local No. .... 354 .....

Date Issued May 25, 2004 *Franklin J. Premuda, M.D.*  
Hammond Health Commissioner

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

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1 DECEASED—NAME (First, Middle, Last) <b>FRANCES J. FREYEK</b>		2 SEX <b>FEMALE</b>		3a. TIME OF DEATH <b>10:30 A.M.</b>		3b. DATE OF DEATH (Month, Day, Yr.) <b>MAY 22, 2004</b>	
4. *SOCIAL SECURITY NUMBER <b>308-18-3411</b>		5a. AGE—Last Birthday (Years) <b>84</b>		5b. UNDER 1 YEAR Months Days		5c. UNDER 1 DAY Hours Minutes	
6. DATE OF BIRTH (Mo, Day, Yr.) <b>APRIL 1, 1920</b>		7. BIRTHPLACE (City and State or Foreign Country) <b>HAMMOND, INDIANA</b>					
8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>		8b. YEAR LAST SERVED IN U.S. ARMED FORCES? <b>N/A</b>		9a. PLACE OF DEATH (Check only one See instructions) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) <b>3841 HENRY AVENUE</b>				9c. CITY, TOWN, OR LOCATION OF DEATH <b>HAMMOND</b>		9d. COUNTY OF DEATH <b>LAKE</b>	
10. MARITAL STATUS (Specify) <b>WIDOWED</b>		11. SURVIVING SPOUSE (If wife, give maiden name) <b>NONE</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>HAMMOND</b>		13d. STREET AND NUMBER <b>3841 HENRY AVENUE</b>	
13e. ZIP CODE <b>46327</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>10</b> College (1-4 or 5+) <b>10</b>					
18. FATHER'S NAME (First, Middle, Last) <b>MATTHEW BALIGA</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA GONIA</b>			
20a. INFORMANT'S NAME (Type/Print) <b>JOHN FREYEK</b>				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3501-44TH ST., HIGHLAND, INDIANA 46322</b>		20c. Relationship <b>SON</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Done on <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>MAY 25, 2004 OAKLAND MEMORY LANES CREMATORY</b>			21c. LOCATION—City or Town, State <b>DOLTON, ILLINOIS</b>		
22a. EMBALMER'S NAME <b>N/A</b>		22b. EMBALMER'S LICENSE NO. <b>N/A</b>		23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Kenneth A. Anthony</i>		24b. LICENSE NUMBER (of Licensee) <b>01011911</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>ANTHONY &amp; DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327</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. <u>Severe Aortic Stenosis</u> DUE TO (OR AS A CONSEQUENCE OF):					Several years
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. <u>Congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF):					Several years
		c. <u>Chronic renal failure</u> DUE TO (OR AS A CONSEQUENCE OF):					Several years
		d.					
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>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.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Franklin J. Premuda, M.D.</i>					
		29c. MEDICAL LICENSE NO. <b>01045772</b>		29d. DATE SIGNED (Month, Day, Year) <b>5-25-04 (man)</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>ABD A. NOGHOUGH M.D. 7400 COLOMBIA AVENUE HAMMOND, INDIANA 46324</b>							
31. HEALTH OFFICER'S SIGNATURE <i>Franklin J. Premuda, M.D.</i>						32. DATE FILED (Month, Day, Year) <b>May 25, 2004</b>	
33. 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		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.			