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50614BK

2005 044452

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF Lake)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2005 JUN -1 AM 9:44

MICHAEL A. BROWN
RECORDER

6250614 BIC

Chicago Title Insurance Company

Elizabeth A. Ring BEING FIRST DULY SWORN UPON her OATH, DEPOSES AND SAYS:

THAT Jennie D. Sobkowicz DIED ON THE 30th DAY OF January, ~~19~~2003 AT Hobart, IN.

THAT AT THE TIME OF her DEATH, she WAS A CO-OWNER AS A JOINT TENANT WITH Elizabeth A. Ring OF THE FOLLOWING DESCRIBED REAL ESTATE:

The South 22 feet of Lot 6 and the North 38 feet of Lot 7 in Block 2 in Hobart Lake Shore Subdivision, in the City of Hobart, as per plat thereof, recorded in Plat Book 21, Page 6, in the Office of the Recorder of Lake County, Indiana.

27-18-0021-0007

THAT NO FEDERAL ESTATE TAX OR INDIANA INHERITANCE TAX IS DUE AS A RESULT OF THE DEATH OF Jennie D. Sobkowicz.

THAT THIS AFFIANT'S RELATIONSHIP TO THE DECEDENT WAS Daughter.

FURTHER AFFIANT SAITH NOT.

Elizabeth A. Ring
Elizabeth A. Ring

BEFORE ME THE UNDERSIGNED NOTARY PUBLIC IN AND FOR SAID COUNTY AND STATE, THIS 11th DAY OF May, ~~19~~ 2005, PERSONALLY APPEARED Elizabeth A. Ring AND ACKNOWLEDGED THE EXECUTION OF THE ABOVE DOCUMENT.

MY COMMISSION EXPIRES:
10-5-09

Patricia L. Zaucki
Patricia L. Czarnecki NOTARY PUBLIC

COUNTY OF RESIDENCE: Porter Co.

THIS INSTRUMENT PREPARED BY Elizabeth Ring Chicago Title Insurance Company

MEGALYN L. SMITH
Lake County
My Commission Expires
December 8, 2007

DULY ENTERED FOR TAXATION SUBJECT TO FINAL ACCEPTANCE FOR TRANSFER

MAY 31 2005

STEPHEN R. STIGLICH

11-7P CT

8240€

50614BK

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.

Local No. 278-03

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

0250614BK

State No.

Chicago Title Insurance Company

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)	2. SEX	3a. TIME OF DEATH	3b. DATE OF DEATH (Month, Day, Yr.)
JENNIE D. SOBKOWICZ	Female	8:54 PM M	January 30, 2003

4. *SOCIAL SECURITY NUMBER	5a. AGE—Last Birthday (Years)	5b. UNDER 1 YEAR (Months / Days)	5c. UNDER 1 DAY (Hours / Minutes)	6. DATE OF BIRTH (Mo. Day. Yr.)	7. BIRTHPLACE (City and State or Foreign Country)
313-30-5249	85			July 10, 1917	East Chicago Indiana

8a. WAS DECEDENT A U.S. VETERAN?	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions)
No	N/A	HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Other (Specify) ☐ Residence

9b. FACILITY NAME (If not institution, give street and number)	9c. CITY, TOWN, OR LOCATION OF DEATH	9d. COUNTY OF DEATH
St. Mary Medical Center	Hobart	Lake

10. MARITAL STATUS (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)	12b. KIND OF BUSINESS/INDUSTRY
Widowed	N/A	Homemaker	Home

13a. RESIDENCE—STATE	13b. COUNTY	13c. CITY, TOWN, OR LOCATION	13d. STREET AND NUMBER
Indiana	Lake	Hobart	145 S. Delaware St.

13e. ZIP CODE	13f. INSIDE CITY LIMITS	13g. ON A FARM?	14. CITIZEN OF WHAT COUNTRY?	15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc (Specify)	17. DECEDENT'S EDUCATION (Specify only highest grade completed)	
46342	☐ No ☒ Yes	☒ No ☐ Yes	U.S.A.	☒ No ☐ Yes	White	Elementary/Secondary (0-12): 8	College (1-4 or 5 +)

PARENTS

18. FATHER'S NAME (First, Middle, Last)	19. MOTHER'S NAME (First, Middle, Maiden Surname)
Frank Zaborowski	Anna Noga

INFORMANT

20a. INFORMANT'S NAME (Type/Print)	20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	20c. Relationship
Dolores Little	2909 W. 37th Avenue, Hobart, IN 46342	Daughter

DISPOSITION

21a. METHOD OF DISPOSITION	21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)	21c. LOCATION—City or Town, State
☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)	Feb 3, 2003 Holy Cross Cemetery	Calumet City IL

22a. EMBALMER'S NAME	22b. EMBALMER'S LICENSE NO	23. WAS DEATH REPORTED TO CORONER?
James J. Krause	FD01006463	☒ No ☐ Yes

24a. SIGNATURE OF FUNERAL DIRECTOR	24b. LICENSE NUMBER (of Licensee)	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME
[signature]	FD01006463	Rees Funeral Home, Inc. FH83003069 600 W. Old Ridge Road, Hobart, IN 46342-0488

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. CHOLECYSTITIS	WEEKS
	DUE TO (OR AS A CONSEQUENCE OF): CIRRHOSIS	month
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last	b. CARDIOMYOPATHY	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

FEB 04 2003

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)	28a. WAS AN AUTOPSY PERFORMED? (Yes or no)	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)
	No	No	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.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. MEDICAL LICENSE NO.	29d. DATE SIGNED (Month, Day, Year)
[signature]	0105258BA	2/3/03

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): Raied Abdullah MD 4802 Broadway, Gary, IN 46408

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: [signature] D.O

32. DATE FILED (Month, Day, Year): February 4, 2003

33. MANNER OF DEATH	34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)	34d. DESCRIBE HOW INJURY OCCURRED
☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined				

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.

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