

SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 007683

2006 FEB -1 7:01:06

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On this 27th day of January, 2006 before me personally appeared Terri Butler

NOTARY PUBLIC
RECORDED

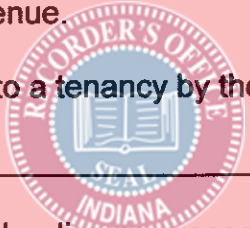
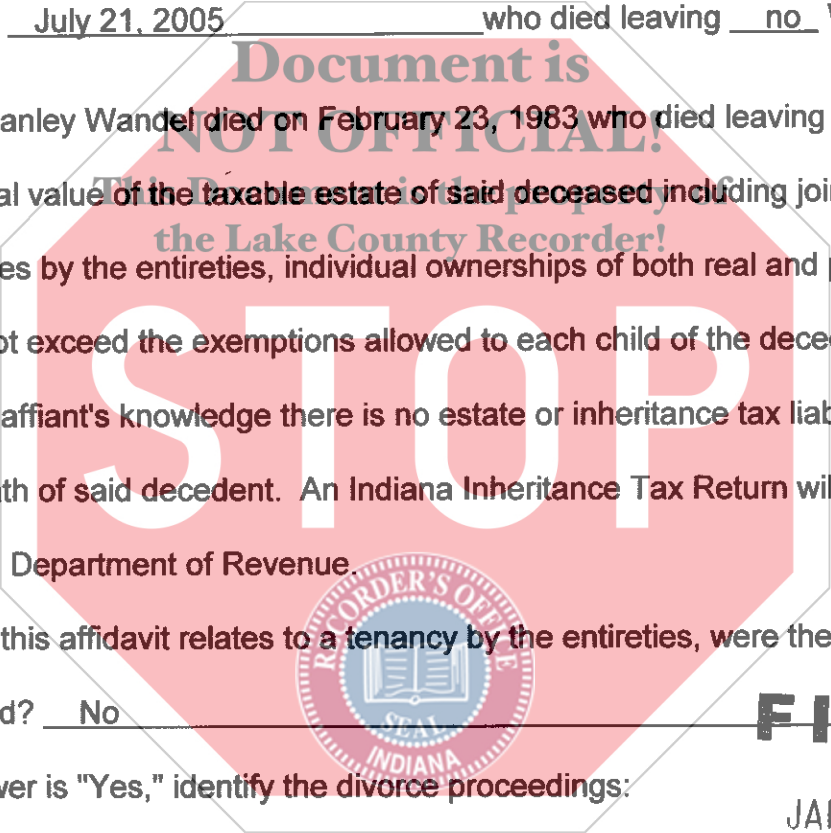
to me personally known, who being duly sworn on oath did say that :

1. Affiant resides at the address given below affiant's signature;
2. Affiant is daughter of the late Lottie Wandel and Stanley Wandel;
(state interest of affiant in the above premises as "owner," "son of owner," etc.)
3. Said premises was formerly owned by Lottie Wandel and Stanley F. Wandel, as Joint Tenants with Rights of Survivorship;
4. Said Lottie Wandel
(fill in name of co-tenant who died)

33-171-19+20
(26)

died on July 21, 2005 who died leaving no Will.

5. Said Stanley Wandel died on February 23, 1983 who died leaving no Will.
6. The total value of the taxable estate of said deceased including joint tenancies, tenancies by the entireties, individual ownerships of both real and personal property, does not exceed the exemptions allowed to each child of the decedent, and to the best of affiant's knowledge there is no estate or inheritance tax liability by reason of the death of said decedent. An Indiana Inheritance Tax Return will be filed with the Indiana Department of Revenue.
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:



FILED

JAN 31 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

8. Affiant's relationship to the deceased was Daughter

Signature: Terri Butler
Terri Butler
Address: 9153 Columbia Ave.
St. John, IN 46373

Subscribed and sworn to before me by the affiant this 27th day of January 2006.
(insert date)

Suzanne Goldsmith
Suzanne Goldsmith, Notary Public and
Resident of Lake County, IN

My Commission Expires 11/27/07

This instrument prepared by Joni M. Ritzl, Attorney at Law, Attorney #16182-45

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ZP
TJ

* 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
Date issued July 28, 2005
Hammond Health Commissioner

Local No. 496

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) LOTTIE A. WANDEL		2. SEX FEMALE	3a. TIME OF DEATH 11:05 AM	3b. DATE OF DEATH (Month, Day, Yr.) JULY 21, 2005
4. *SOCIAL SECURITY NUMBER XXXXXXXXXX	5a. AGE—Last Birthday (Years) 82	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) JANUARY 27, 1923
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		8c. PLACE OF DEATH (Check only one. See instructions.) HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input checked="" type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) 4414 JOHNSON AVENUE		9c. CITY, TOWN, OR LOCATION OF DEATH HAMMOND	9d. COUNTY OF DEATH LAKE	
10. MARITAL STATUS (Specify) WIDOWED	11. SURVIVING SPOUSE (If wife, give maiden name) NONE	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HOMEMAKER		12b. KIND OF BUSINESS/INDUSTRY OWN HOME
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND	13d. STREET AND NUMBER 4414 JOHNSON AVENUE	
13e. ZIP CODE 46327	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? USA	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) WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) STANLEY GORCZYCA		
19. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES FURMAN		20a. INFORMANT'S NAME (Type/Print) THERESA BUTLER		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9153 COLUMBIA, ST. JOHN, INDIANA 46373		20c. Relationship DAUGHTER		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <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) JULY 25, 2005 HOLY CROSS CEMETERY		21c. LOCATION—City or Town, State CALUMET CITY, ILLINOIS
22a. EMBALMER'S NAME KEITH D. ANTHONY		22b. EMBALMER'S LICENSE NO. 01011911	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Keith D. Anthony</i>		24b. LICENSE NUMBER (of Licensee) 01011911	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ FH 83002835 4404 CAMERON, HAMMOND, INDIANA 46327	
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.				
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. VASCULAR COLLAPSE		Approximate Interval Between Onset and Death UNKNOWN
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last		b. DUE TO (OR AS A CONSEQUENCE OF) DUE TO ARTERIOSCLEROTIC HEART AND VASCULAR DISEASE		
		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) 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) NO	
29a. CERTIFIER (Check only one) <input 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 checked="" 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>Paul R. Castro</i>		29c. MEDICAL LICENSE NO. N/A
29d. DATE SIGNED (Month, Day, Year) JULY 25, 2005		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) PAUL R. CASTRO, CHIEF INVESTIGATOR, 2900 WEST 93RD AVENUE, CROWN POINT, INDIANA 46307		
31. HEALTH OFFICER'S SIGNATURE <i>DR. R. R. ...</i>		32. DATE FILED (Month, Day, Year) July 28, 2005		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be Determined		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) JULY 21, 2005		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

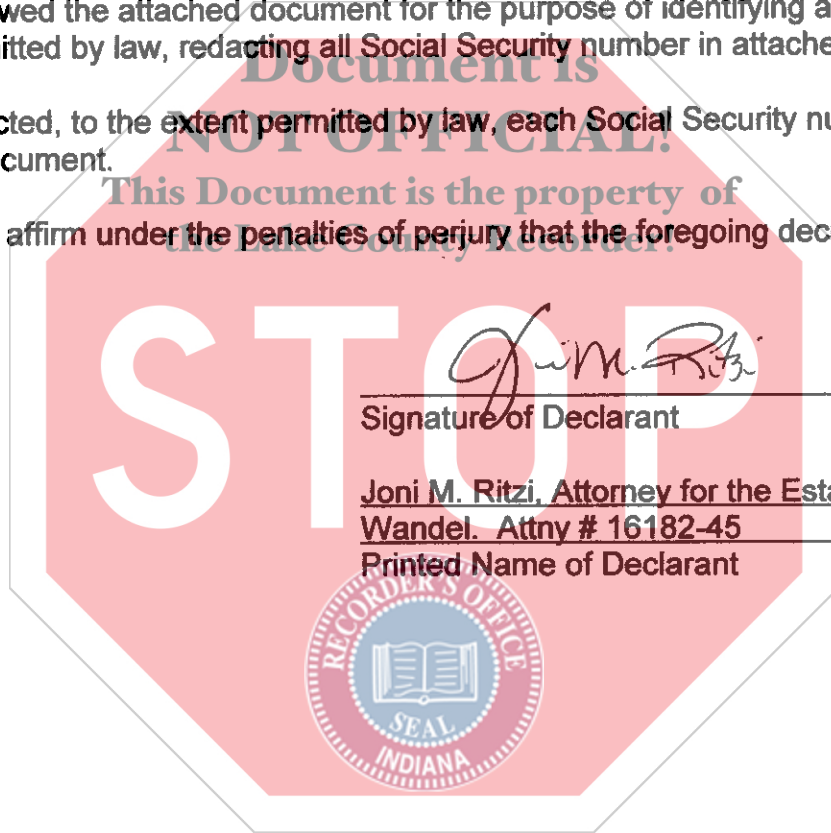
Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned prepare of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and to the extent permitted by law, redacting all Social Security number in attached document.
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury that the foregoing declarations are true.



Joni M. Ritzi

Signature of Declarant

Joni M. Ritzi, Attorney for the Estate of Lottie Wandel. Attny # 16182-45

Printed Name of Declarant