SURVIVORSHIP AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 007683

2006 FEB -1 AM 9:06

VICKI L. BROWN
RECORDER

3

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

FILED

JAN 31 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

(If answer is "Yes," identify the divorce proceedings:);

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, Notary Public and
Resident of Lake County, IN

My Commission Expires 11/27/07

14-
ZP
II

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

Ticor Title - Schererville 920059480

001949

* **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. 496

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

July 28 2005 — Date Issued — R R Kanare MD — Hammond Health Commissioner

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): 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: XXX-XX-XXXX
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
9a. PLACE OF DEATH (Check only one. See instructions.): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☒ Residence
9b. 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: ☐ No ☒ Yes
13g. ON A FARM?: ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY?: USA
15. WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify Cuban, Mexican, Puerto Rican, etc.): ☒ No ☐ Yes
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 +):

PARENTS

18. FATHER'S NAME (First, Middle, Last): STANLEY GORCZYCA
19. MOTHER'S NAME (First, Middle, Maiden Surname): AGNES FURMAN

INFORMANT

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

DISPOSITION

21a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ 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?: ☐ No ☒ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Keith D Anthony
24b. LICENSE NUMBER (of Licensee): 01011911
25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME: ANTHONY & DZIADOWICZ FH 83002835, 4404 CAMERON, HAMMOND, INDIANA 46327

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.

IMMEDIATE CAUSE (Final disease or condition resulting in death):
a. VASCULAR COLLAPSE — Approximate Interval Between Onset and Death: UNKNOWN
DUE TO (OR AS A CONSEQUENCE OF)
b. DUE TO ARTERIOSCLEROTIC HEART AND VASCULAR DISEASE
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

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

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: Paul R Castro
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

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: R R Kanare MD
32. DATE FILED (Month, Day, Year): July 28 2005

33. MANNER OF DEATH: ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ 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.:

Prescribed by the
State Board of Accounts
(2005)

County Form 170

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.

Signature of Declarant

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