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STATE OF INDIANA )  
 ) SS: IN THE LAKE CIRCUIT COURT  
COUNTY OF LAKE ) SITTING IN CROWN POINT, INDIANA

2006 008770

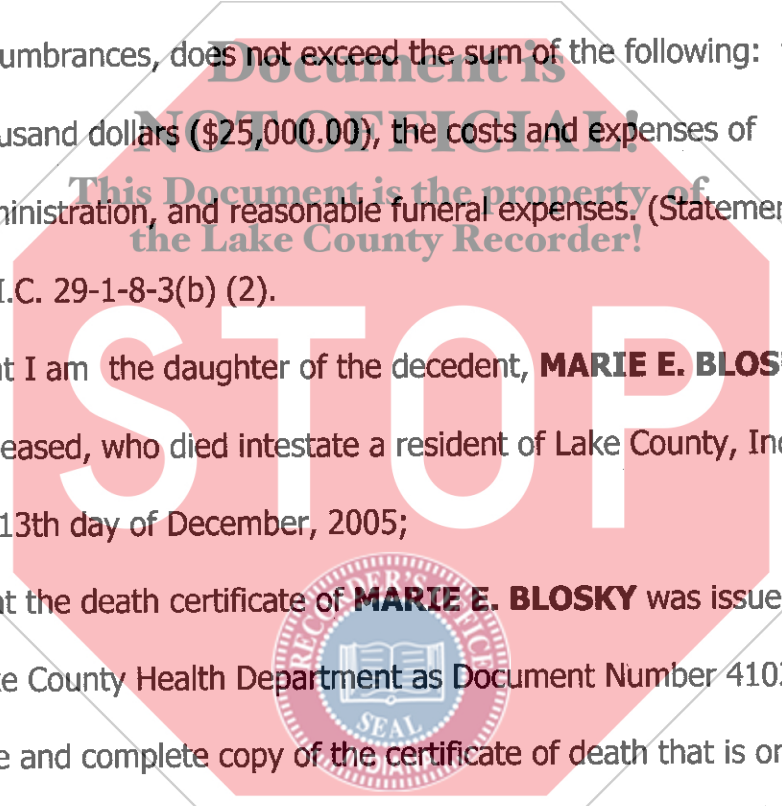
IN RE: THE MATTER OF )  
MARIE E. BLOSKY, DECEASED ) CAUSE NO. 45C01-

**I.C 29-1-8-3 AFFIDAVIT FOR MARIE E. BLOSKY**

Comes now **SUSAN M. DAY**, who being duly sworn upon her oath states  
as follows:

- A. That this affidavit is prepared, made, and filed in accordance with I.C. 29-1-8-3, Indiana Statutes.
- B. That it appears that the decedent's gross probate estate, less liens and encumbrances, does not exceed the sum of the following: twenty-five thousand dollars (\$25,000.00), the costs and expenses of administration, and reasonable funeral expenses. (Statement required by I.C. 29-1-8-3(b) (2).
- C. That I am the daughter of the decedent, **MARIE E. BLOSKY**, deceased, who died intestate a resident of Lake County, Indiana, on the 13th day of December, 2005;
- D. That the death certificate of **MARIE E. BLOSKY** was issued by the Lake County Health Department as Document Number 4102-05 and a true and complete copy of the certificate of death that is on file with the Lake County Health Department is attached hereto as Exhibit
- D, That **MARIE E. BLOSKY** left surviving her following heirs at law:

STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD  
2006 FEB -3 AM 10:58  
MICHAEL A. BREWEN  
RECORDER



**FILED**

002352

FEB 03 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

20.00  
010  
1039

- |    |                          |          |
|----|--------------------------|----------|
| 1. | <b>William J. Blosky</b> | Son      |
| 2. | <b>Mary E. Hill</b>      | Daughter |
| 3. | <b>John T. Blosky</b>    | Son      |
| 4. | <b>Carol L. Hale</b>     | Daughter |
| 5. | <b>Susan M. Day</b>      | Daughter |

E. That the foregoing five (5) children are the only children of **MARIE BLOSKY** and she had no others;

F. That **MARIE E. BLOSKY**, decedent, left no other child or children, or descendants of any predeceased child or children, and that all survivors are competent adults and the only children of **MARIE E. BLOSKY**;

G. That at the time of her death, **MARIE E. BLOSKY** was not married;

H. That the statements made in this affidavit are true and completes and are made for the purposes of complying with the provisions of I.C. 29-1-8-3(b).

I. That at the time of her death **MARIE E. BLOSKY** was the sole owner of the real estate located at 8821 Schneider, Unit 33, Highland, Indiana

46322, Key Number 16-27-604-1, whose legal description is as follows:  
 UNIT 33 together with an undivided 2.3986 percent interest in the Eagle Ridge Horizontal Property Regime, as set forth in the Declaration of Condominium Ownership made by Highvest Properties, an Illinois General Partnership, recorded May 2, 1995, in Book 78, Page 35, as Document no. 95023865, all in the Southwest ¼ of Section 21, Township 36 North, Range 9 West of the Second Principal Meridian, in Lake County, Indiana. (legal description required by I.C. 29-1-8-3(b)(1))

Key Number(s): 27-10-88; 27-10-87; 27-10-86,

J. That by operation of intestate law the aforementioned **WILLIAM J. BLOSKY, MARY E. HILL, JOHN T. BLOSKY, CAROL L. HALE, AND SUSAN M. DAY** became the owners of the above property on the date of the death of **MARIE E. BLOSKY** with each of the parties now holding in title and are the owners of a one fifth (1/5) interest as a tenant in common in the real estate listed above (Statement required by I.C. 29-1-8-3(b)(3)).

K. Each persons share was determined in accordance with the laws of intestacy of the State of Indiana and more specifically I.C. 29-11-2-1 and by operation of intestate law the aforementioned **WILLIAM J. BLOSKY, MARY E. HILL, JOHN T. BLOSKY, CAROL L. HALE, AND SUSAN M. DAY** are the only children of **MARIE E. BLOSKY** who was not married at the time of her death and that **MARIE E. BLOSKY** was the sole owner of the aforementioned real estate at the time of here death. (This statement is required by I.C. 29-1-8-3(b)(4)).

L. That this affidavit meets the requirements of I.C. 29-1-8 and more specifically I.C. 29-1-8-4.

M. That this affidavit is based upon the personal knowledge of the affiant **SUSAN M. DAY**.

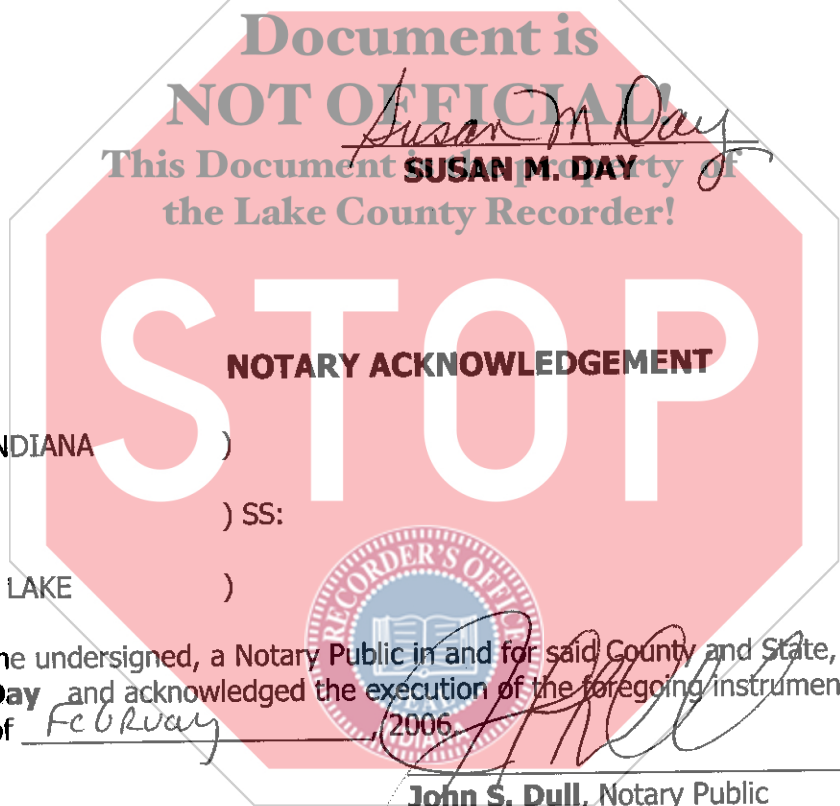
N. That the affidavit is prepared for the purpose of complying with the provisions of I.C. 29-1-8-3 and more specifically I.C. 29-1-8-3(b).

FURTHER THE AFFIANT **SUSAN M. DAY** SAYETH NOT.

*Susan M Day*  
**SUSAN M. DAY**

**VERIFICATION**

I swear under the penalties of perjury that the foregoing statements made under oath are true and correct and are based upon my personal knowledge.

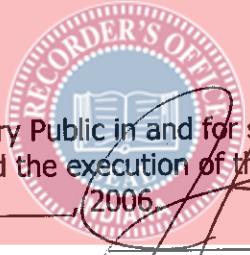


STATE OF INDIANA )

) SS:

COUNTY OF LAKE )

Before me the undersigned, a Notary Public in and for said County and State, came **Susan M. Day** and acknowledged the execution of the foregoing instrument this 2nd day of February, 2006.



*John S. Dull*  
**John S. Dull**, Notary Public  
Commission Expires: May 5, 2009  
Lake County Resident

Document Prepared By Attorney **John S. Dull**, PO Box 14058, Merrillville, In 46411-4058

↗

ATTENTION ESTATE: The Social Security # is requested by this state agency in order to sue its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

# INDIANA STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

State No. ....

RE/PRINT  
IN  
PERMANENT  
BLACK INK

DECEDENT

EVENTS

FORMANT

POSITION

USE OF  
THIS

TIFIER

LTH  
ICER

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

1. DECEASED—NAME (First, Middle, Last) <b>MARIE ELLEN BLOSKY</b>		2. SEX <b>FEMALE</b>	3a. TIME OF DEATH <b>3:34 A.M.</b>	3b. DATE OF DEATH (Month, Day, Yr.) <b>DECEMBER 13, 2005</b>	
4. SOCIAL SECURITY NUMBER <b>304-32-8582</b>	5a. AGE—Last Birthday (Years) <b>71</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr.) <b>APRIL 14, 1934</b>	
7. BIRTHPLACE (City and State or Foreign Country) <b>EAST CHICAGO, 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 checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence			
9b. FACILITY NAME (If not institution, give street and number) <b>THE COMMUNITY HOSPITAL</b>		9c. CITY, TOWN, OR LOCATION OF DEATH <b>MUNSTER</b>	9d. COUNTY OF DEATH <b>LAKE</b>		
10. MARITAL STATUS (Specify) <b>DIVORCED</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>N/A</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>CLERICAL</b>		12b. KIND OF BUSINESS/INDUSTRY <b>CHURCH</b>	
13a. RESIDENCE—STATE <b>INDIANA</b>	13b. COUNTY <b>LAKE</b>	13c. CITY, TOWN, OR LOCATION <b>HIGHLAND</b>	13d. STREET AND NUMBER <b>8821 SCHNEIDER UNIT 33</b>		
13e. ZIP CODE <b>46322</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 (10-12) <b>12</b> College (1-4 or 5+) <b></b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LINDA DeROSA</b>			
18. FATHER'S NAME (First, Middle, Last) <b>SALVATORE BENEDETTO</b>		19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LINDA DeROSA</b>			
20a. INFORMANT'S NAME (Type/Print) <b>SUSAN DAY</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1235 ELLISTON COURT, CROWN POINT, IN 46307</b>		20c. Relationship <b>DAUGHTER</b>	
21a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <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) <b>DECEMBER 15, 2005 KELLY-CARROLL CREMATION SERVICES</b>		21c. LOCATION—City or Town, State <b>GARY, INDIANA</b>	
22a. EMBALMER'S NAME <b>SCOTT PREWITT</b>		22b. EMBALMER'S LICENSE NO. <b>FDO1006861</b>		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) <b>FDO1006015</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>FAGEN MILLER FUNERAL HOME 2828 HIGHWAY AVENUE HIGHLAND, INDIANA 46322 FH8300303</b>	
26. PART I. Enter the disease, 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. <b>Respiratory failure</b>					
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): 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) <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 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>[Signature]</i>			29c. MEDICAL LICENSE NO. <b>01032690</b>	29d. DATE SIGNED (Month, Day, Year) <b>12-13-05</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>DR SAMI AHMADZAI 6924 INDIANAPOLIS BLVD., HAMMOND, INDIANA</b>					
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>				DATE FILED (Month, Day, Year) <b>2005 December 13</b>	
33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Suicide <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 THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. <b>JAN 04 2006</b>
		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.			

Prescribed by the  
State Board of Accounts  
(2005)

County form 170

Declaration

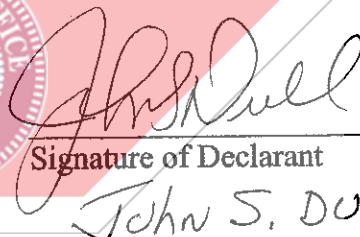
This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer 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

John S. DULL

Printed Name of Declarant