



TICOR TITLE INSURANCE

2006 010032

AFFIDAVIT

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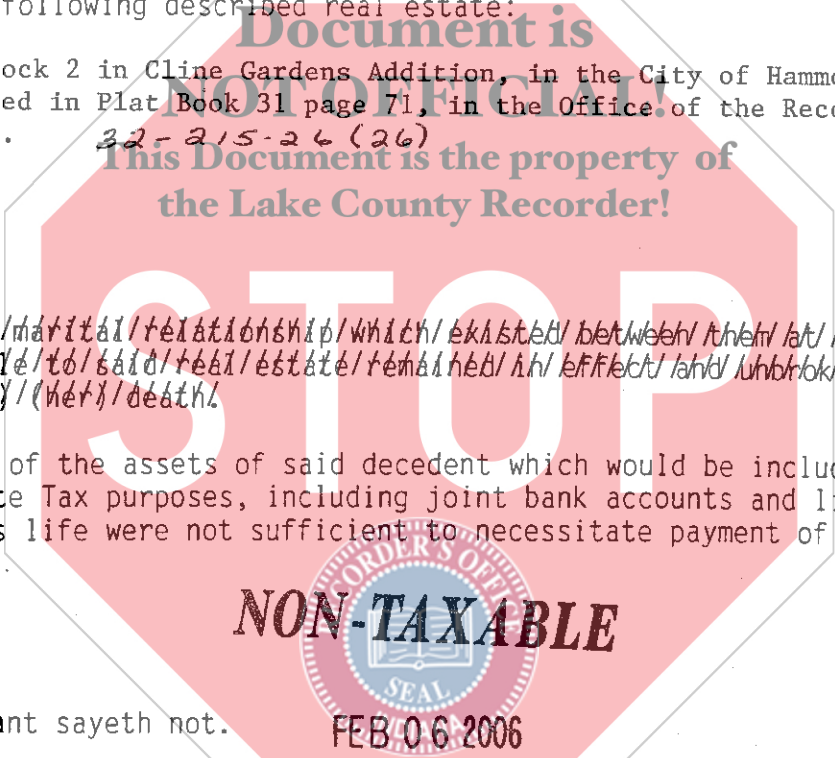
STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

James Jamroz, being first duly sworn upon oath, deposes and says:

1. That Peter J. Jamroz died October 21, 192004 at Munster, Indiana

2. That Peter J. Jamroz and James Jamroz ~~met and lawfully~~ legally married at the time they acquired title as ~~husband and wife~~ husband and wife to the following described real estate:

Lot 3 in Block 2 in Cline Gardens Addition, in the City of Hammond, as per plat thereof, recorded in Plat Book 31 page 71, in the Office of the Recorder of Lake County, Indiana. 22-215-26(26)



~~3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of his death.~~

4. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

NON-TAXABLE

FEB 06 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

James Jamroz
James Jamroz

Subscribed and sworn to before me, a Notary Public, this 31st day of January, 192006.

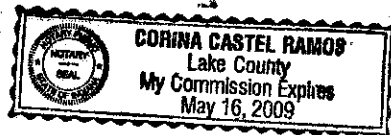
Corina Castel Ramos

Notary Public
Corina Castel Ramos

My Commission expires: May 16, 2009

County of Residence:

Lake



14-EP-TH

This Instrument prepared by James Jamroz

002522

925-9955
TICOR HO

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

State No.

Local No. 2663-04

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) PETER JAMROZ				2. SEX MALE		3a. TIME OF DEATH 3:52 P.M.		3b. DATE OF DEATH (Month, Day, Year) OCT 21, 2004				
4. SOCIAL SECURITY NUMBER XXXXXXXXXX		5a. AGE—Last Birthday (Years) 91		5b. UNDER 1 YEAR Months—Days		5c. UNDER 1 DAY Hours—Minutes		6. DATE OF BIRTH (Mo, Day, Yr) JUN 25, 1913		7. BIRTHPLACE (City and State or Foreign Country) EAST CHICAGO IN		
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: <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) COMMUNITY HOSPITAL						9c. CITY, TOWN, OR LOCATION OF DEATH MUNSTER			9d. COUNTY OF DEATH LAKE			
10. MARITAL STATUS (Specify) WIDOWED		11. SURVIVING SPOUSE (If wife, give maiden name) N/A			12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) HELPER OPEN HEARTH			12b. KIND OF BUSINESS/INDUSTRY STEEL MILL				
13a. RESIDENCE—STATE INDIANA		13b. COUNTY LAKE		13c. CITY, TOWN, OR LOCATION HAMMOND			13d. STREET AND NUMBER 6710 NEW JERSEY					
13a. ZIP CODE 46323		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) FRANK JAMROZ						19. MOTHER'S NAME (First, Middle, Maiden Surname) TEKLA STYPA						
20a. INFORMANT'S NAME (Type/Print) JOAN BLUETHMANN				20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9436 ANTHONY PL HIGHLAND IN 46322				20c. Relationship DAUGHTER				
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Entombment <input type="checkbox"/> Burial <input 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) OCT 25, 2004 ST JOHN ST JOSEPH CEMETERY				21c. LOCATION—City or Town, State HAMMOND IN				
22a. EMBALMER'S NAME JAMES W GHOLSTON				22b. EMBALMER'S LICENSE NO. 1004194		23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes						
24a. SIGNATURE OF FUNERAL DIRECTOR <i>John B. Lesniak</i>				24b. LICENSE NUMBER (of Licensee) 1005491		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME LESNIAK FH 83001601 4918 MAGOUN E. CHICAGO IN 46312						
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. <i>Acute congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>due to ventricular fibrillation</i> 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										Approximate Interval Between Onset and Death		
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 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>A. Blumenthal</i>				29c. MEDICAL LICENSE NO. 01025591		29d. DATE SIGNED (Month, Day, Year) 10-27-04				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) A STEMER MD 761 45TH AVE MUNSTER IN 46321												
31. HEALTH OFFICER'S SIGNATURE <i>Steven W. Burt, D.O.</i>						32. DATE FILED (Month, Day, Year) October 28, 2004						
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			
34a. 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.



Chris Burk

Signature of Declarant

Chris Burk

Printed Name of Declarant

Verified for Recording by
Ticor Title Insurance Company