

CHICAGO TITLE INSURANCE COMPANY

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2006 016277

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 NOV -1 AM 9:49

MICHAEL A. BROWN
RECORDER

AFFIDAVIT OF PAUL ERIC POLAK

I, Paul Eric Polak, being duly sworn, affirm under the penalties for perjury that I am an adult under no mental or physical incapacity or disability and am competent to testify to the facts set forth in this Affidavit and state as follows:

- 1. I am one of three surviving sons of Paul P. Polak and Shirley L. Polak.
- 2. On June 5, 2003, my father, Paul P. Polak died as a result of acute hypoxic encephalopathy and atherosclerotic vascular disease in Munster, Indiana. I have attached a certified copy of the Certificate of Death for Paul P. Polak to this Affidavit.

3. On December 13, 2003, my mother, Shirley L. Polak died as a result of acute myocardial infarction, chronic renal failure and chronic obstructive pulmonary disease in Munster, Indiana. I have attached a certified copy of the Certificate of Death for Shirley L. Polak to this Affidavit.

4. At the time of their death, Paul P. Polak and Shirley L. Polak owned real estate situated in Munster, Lake County, Indiana, jointly as husband and wife, which is described as follows:
 Lot Five (5), Block (2), in the Knickerbocker Manor Third Addition to the Town of Munster, Lake County, Indiana, per recorded plat thereof.
 Commonly known as 224 Evergreen Lane, Munster, Indiana.

DULY ENTERED FOR TAXATION SUBJECT TO
LOCAL ACCEPTANCE FOR TRANSFER

FEB 28 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

5. As a result of Paul P. Polak's death, Shirley L. Polak became the surviving joint tenant and sole owner of said real estate.

6. At the time of her death, Shirley L. Polak was a widowed, unmarried woman.

7. Shirley L. Polak died with a Last Will & Testament dated February 9, 1976, and a First Codicil to the Last Will and Testament of Shirley L. Polak dated November 15, 2002, naming me, Paul Eric Polak, as Executor and providing for a substantially equal distribution of her estate between her surviving children.

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6. There are no estate proceedings currently pending as a result of the death of Shirley L. Polak.

9. Shirley L. Polak was survived by three sons, Paul Eric Polak, Craig Polak and Brian James Polak. Shirley L. Polak was not survived by any other children.

10. Pursuant to the terms of the Last Will & Testament of Shirley L. Polak and in accordance to the laws of intestacy in the State of Indiana found in I.C. 29-1-2-1(d)(1), the real property that Shirley L. Polak owned at the time of her death transferred in equal shares to her surviving sons, Paul Eric Polak, Craig Polak and Brian James Polak.

11. There was no Federal Estate tax due as a result of the death of Shirley L. Polak.

12. There was no Indiana Inheritance tax due as a result of the death of Shirley L. Polak.

13. The payment of the claims of creditors, if any, has been made, including the expenses of the last illness and death. To my knowledge, there are no outstanding claims of creditors of Shirley L. Polak.

FURTHER AFFIANT SAYETH NOT

Paul Eric Polak
PAUL ERIC POLAK

STATE OF INDIANA)

) SS:

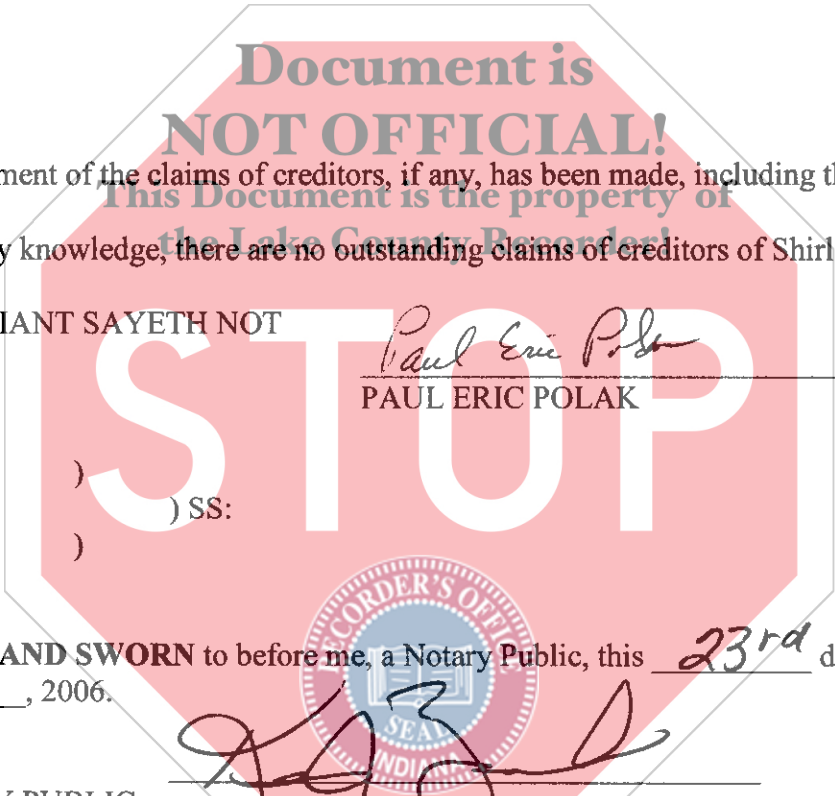
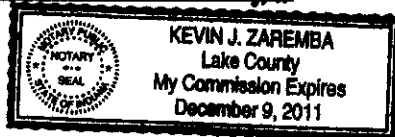
COUNTY OF LAKE)

SUBSCRIBED AND SWORN to before me, a Notary Public, this 23rd day of FEBRUARY, 2006.

NOTARY PUBLIC

Printed Name: KEVIN J. ZAREMBA

My Commission Expires:
Resident of LAKE County.



* 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. 1401-03

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) <u>Paul P. Polak</u>				2 SEX <u>M</u>		3a TIME OF DEATH <u>10:22 AM</u>		3b DATE OF DEATH (Month, Day, Yr.) <u>June 5, 2003</u>				
4 *SOCIAL SECURITY NUMBER <u>305/20/0448</u>		5a AGE—Last Birthday (Years) <u>77</u>		5b UNDER 1 YEAR Months Days		5c UNDER 1 DAY Hours Minutes		6 DATE OF BIRTH (Mo, Day, Yr) <u>Sept. 2, 1925</u>		7 BIRTHPLACE (City and State or Foreign Country) <u>Whiting, In</u>		
8a WAS DECEDENT A U.S. VETERAN? <u>Yes</u>		8b YEAR LAST SERVED IN U.S. ARMED FORCES? <u>WW II</u>		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) <u>Community Hospital</u>						9c CITY, TOWN, OR LOCATION OF DEATH <u>Munster</u>			9d COUNTY OF DEATH <u>Lake</u>			
10 MARITAL STATUS (Specify) <u>Married</u>		11 SURVIVING SPOUSE (If wife, give maiden name) <u>Shirley Lagerberg</u>		12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <u>Electrician</u>				12b KIND OF BUSINESS/INDUSTRY <u>Steel</u>				
13a RESIDENCE—STATE <u>In.</u>		13b COUNTY <u>Lake</u>		13c CITY, TOWN, OR LOCATION <u>Munster</u>			13d STREET AND NUMBER <u>224 Evergreen Ln.</u>					
13e ZIP CODE <u>46320</u>		13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		14 CITIZEN OF WHAT COUNTRY? <u>USA</u>		15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>No</u>		16 RACE—American Indian, Black, White, etc. (Specify) <u>W</u>		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>		
18 FATHER'S NAME (First, Middle, Last) <u>Paul Polak</u>						19 MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Hareznik</u>						
20a INFORMANT'S NAME (Type/Print) <u>Paul E. Polak</u>				20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8108 Forest Ave. Munster, In. 46320</u>				20c Relationship <u>Son</u>				
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) <u>June 9, 2003</u> <u>Northwest Indiana Cremation Ser.</u>				21c LOCATION—City or Town, State <u>Crown Point, In.</u>				
22a EMBALMER'S NAME <u>None</u>				22b EMBALMER'S LICENSE NO. <u>None</u>				23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes				
24a SIGNATURE OF FUNERAL DIRECTOR 				24b LICENSE NUMBER (of Licensee) <u>1013612</u>		25 NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <u>McCoy Funeral Chapel</u> <u>5713 Hohman Ave. Hammond, In. 46320</u> 83002877						
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) <u>Acute hypoxic encephalopathy</u> <u>atherosclerotic vasculature</u> Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <u>Cerebral vasculature</u> <u>accident</u> 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) <u></u>				28a WAS AN AUTOPSY PERFORMED? (Yes or no) <u></u>				28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) <u></u>				
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 						29c MEDICAL LICENSE NO. <u>03001520A</u>		29d DATE SIGNED (Month, Day, Year) <u>6/8/03</u>				
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <u>1573n. Clark Ave Griffith In 46319</u>												
31 HEALTH OFFICER'S SIGNATURE <u>Susan J. Best</u>						32 DATE FILED (Month, Day, Year) <u>JUN 11 2003</u>						
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 PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify) <u></u>				
								34f LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>MUN 1 IN 2003</u>				
34g DATE PRONOUNCED DEAD (Month, Day, Year)				34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.								

* 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. 3051-03

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

TYPE/PRINT IN PERMANENT BLACK INK

Form with fields for: 1. DECEASED—NAME (First, Middle, Last) Shirley L. Polak; 2. SEX F; 3a. TIME OF DEATH 1:44 AM; 3b. DATE OF DEATH (Month, Day, Yr) December 13, 2003; 4. SOCIAL SECURITY NUMBER 306/28/0752; 5a. AGE—Last Birthday (Years) 75; 5b. UNDER 1 YEAR Months Days; 5c. UNDER 1 DAY Hours Minutes; 6. DATE OF BIRTH (Mo, Day, Yr) Apr. 25, 1928; 7. BIRTHPLACE (City and State or Foreign Country) Hammond, In.; 8a. WAS DECEDENT A U.S. VETERAN? No; 8b. YEAR LAST SERVED IN U.S. ARMED FORCES? //; 9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: [X] Inpatient [] ER/Outpatient [] DOA; OTHER: [] Nursing Home [] Other (Specify) [] 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) Wid.; 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) Homemaker; 12b. KIND OF BUSINESS/INDUSTRY Domicile; 13a. RESIDENCE—STATE Ind; 13b. COUNTY Lake; 13c. CITY, TOWN, OR LOCATION Munster; 13d. STREET AND NUMBER 224 Evergreen Ln.; 13e. ZIP CODE 46321; 13f. INSIDE CITY LIMITS [] No [X] Yes; 13g. ON A FARM? [X] No [] Yes; 14. CITIZEN OF WHAT COUNTRY? USA; 15. WAS DECEDENT OF HISPANIC ORIGIN? [] No [X] Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.) No; 16. RACE—American Indian, Black, White, etc. (Specify) W; 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) Eric Lageberg; 19. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Peterson; 20a. INFORMANT'S NAME (Type/Print) Paul E. Polak; 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8108 Forest Ave. Munster, In. 46320; 20c. Relationship Son; 21a. METHOD OF DISPOSITION [] Burial [X] Cremation [] Removal from State [] Donation [] Other (Specify); 21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) Dec. 18, 2003 Northwest In. Cremation Sr.; 21c. LOCATION—City or Town, State Crown Point; 22a. EMBALMER'S NAME: None; 22b. EMBALMER'S LICENSE NO.: NONE; 23. WAS DEATH REPORTED TO CORONER? [X] No [] Yes; 24a. SIGNATURE OF FUNERAL DIRECTOR [Signature]; 24b. LICENSE NUMBER (of Licensee) 101361; 25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME 83002877 McCoy Funeral Chapel 5713 Hohman Ave. Hammond, In. 46320; 26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory. THIS CERTIFIES THE ABOVE IS TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH TO BE FILED WITH THE LAKE COUNTY HEALTH DEPT. IMMEDIATE CAUSE OF DEATH: Myocardial Infarction. DUE TO (OR AS A CONSEQUENCE OF): Chronic Renal Failure. Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last: DEC 29 2003 DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary Disease. 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) [X] 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 [Signature]; 29c. MEDICAL LICENSE NO. 02000848A; 29d. DATE SIGNED (Month, Day, Year) DECEMBER 18, 2003; 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) STEVEN MISCHEL, D.O. 222 DOUGLAS STREET HAMMOND, INDIANA 46320; 31. HEALTH OFFICER'S SIGNATURE Susan W. Best D.O.; 32. DATE FILED (Month, Day, Year) December 29, 2003; 33. MANNER OF DEATH [] Natural [] Pending Investigation [] Accident [] Suicide [] Could not be Determined [] Homicide; 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); 34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.

DECEDENT

PARENTS

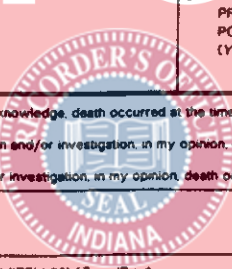
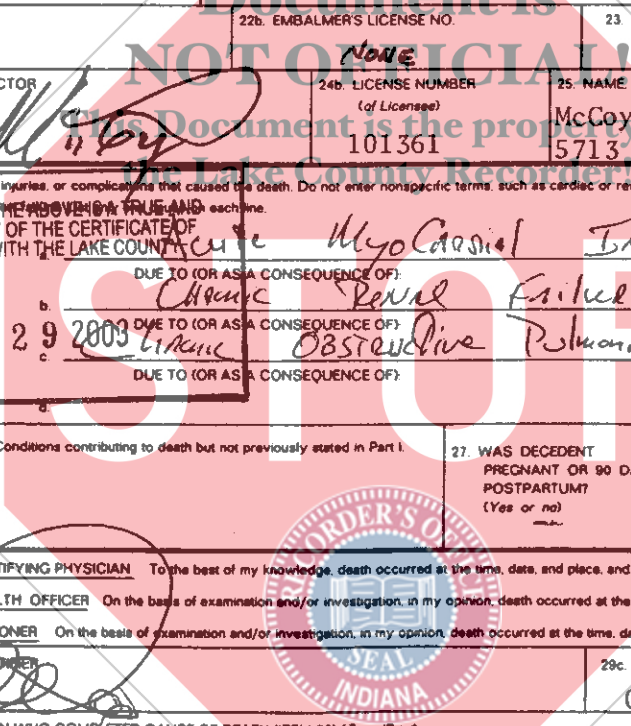
INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

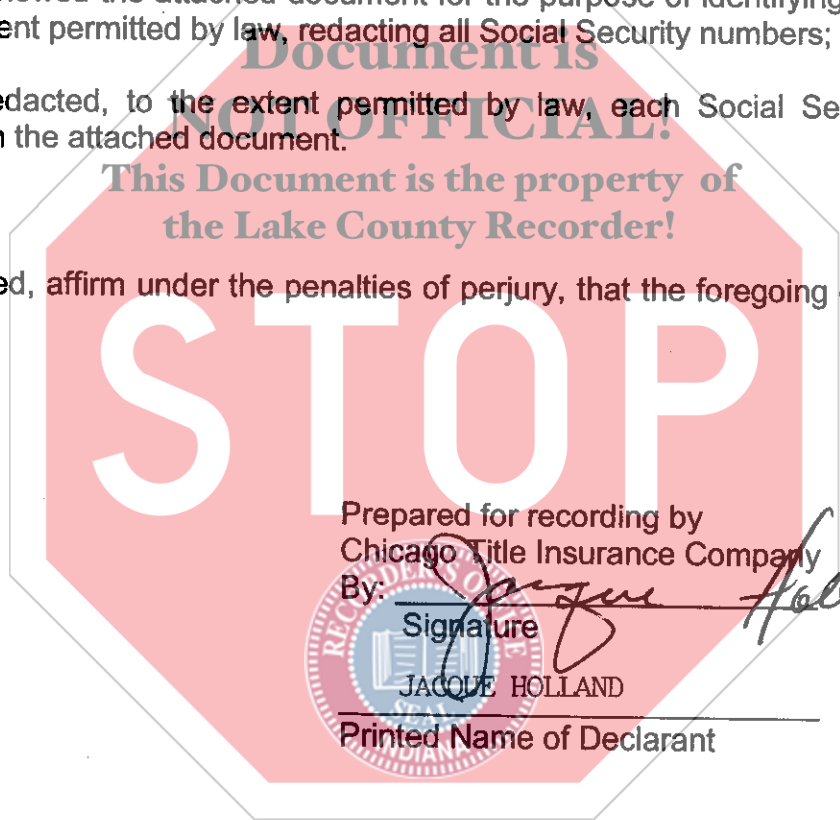


DECLARATION

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under 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 numbers;
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

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



Prepared for recording by
Chicago Title Insurance Company

By:

Signature

JACQUE HOLLAND

Printed Name of Declarant