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STATE OF INDIANA  
LAKE COUNTY  
FILED FOR RECORD

CHIS14449  
State of Indiana  
County of Lake

**AFFIDAVIT AS TO TENANCY BY THE ENTIRETIES**

2006 070045  
)  
)

2006 AUG 11 AM 11:12  
MICHELLE BROWN  
RECORDER

On this 30<sup>th</sup> day of JUNE, 2006, before me personally appeared CHESTER D. CIESIELSKI to me personally known, who being duly sworn on oath did say:

Affiant is the owner of the following property:

**Legal Description**  
CDE 2 \*

LOT 10 IN SLEEPY HOLLOW UNIT, AS PER PLAT THEREOF, RECORDED IN PLAT BOOK 35 PAGE 65, IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA.

PARCEL # 03-07-0241-0010

MORE COMMONLY KNOWN AS: 5707 122ND AVE, CROWN POINT, IN 46307

\* BEING RERECORDED TO CORRECT LEGAL NAME

And that said property was formerly owned as tenants by the entireties, not as joint tenants or as tenants in common by CHESTER D. CIESIELSKI & MARCELLA M. CIESIELSKI and that said: MARCELLA M. CIESIELSKI (deceased spouse) died on the November 24, 2004. A copy of the death certificate is attached.

That the value of the estate of the deceased was less than \$600,000.00 including joint tenancies, tenancies by the entireties, individual ownerships and insurance, and that the tenancy by the entireties had not been severed prior to the death of said deceased.

**FILED**

AUG 11 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

15196

**FILED**

JUL - 6 2006

PEGGY HOLINGA KATONA  
LAKE COUNTY AUDITOR

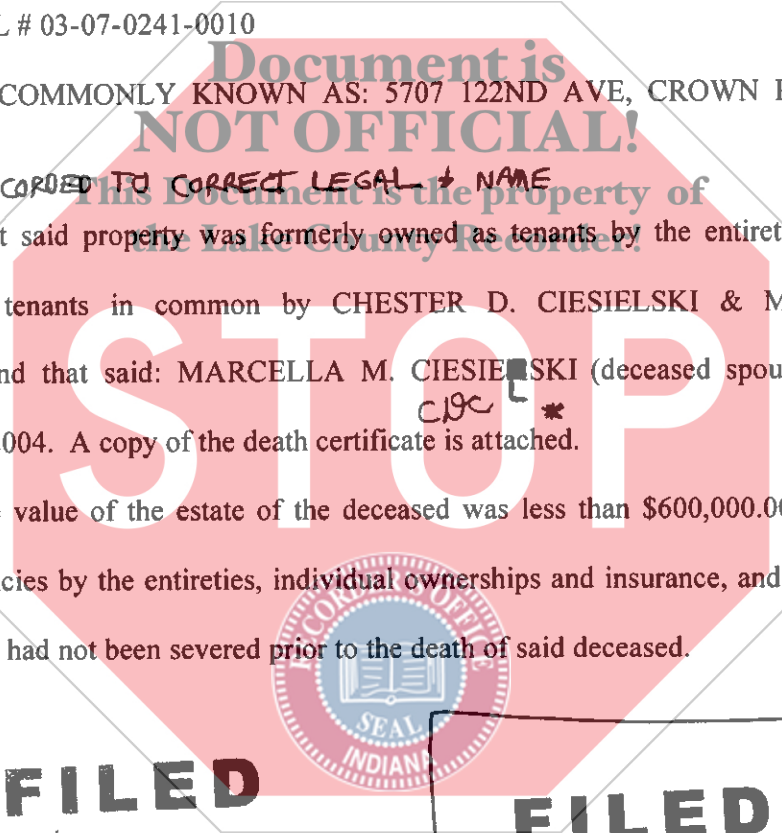
2006 JUL - 6 AM 10:56  
MICHELLE BROWN  
RECORDER  
FILED FOR RECORD  
LAKE COUNTY  
INDIANA

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CDE

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NETO  
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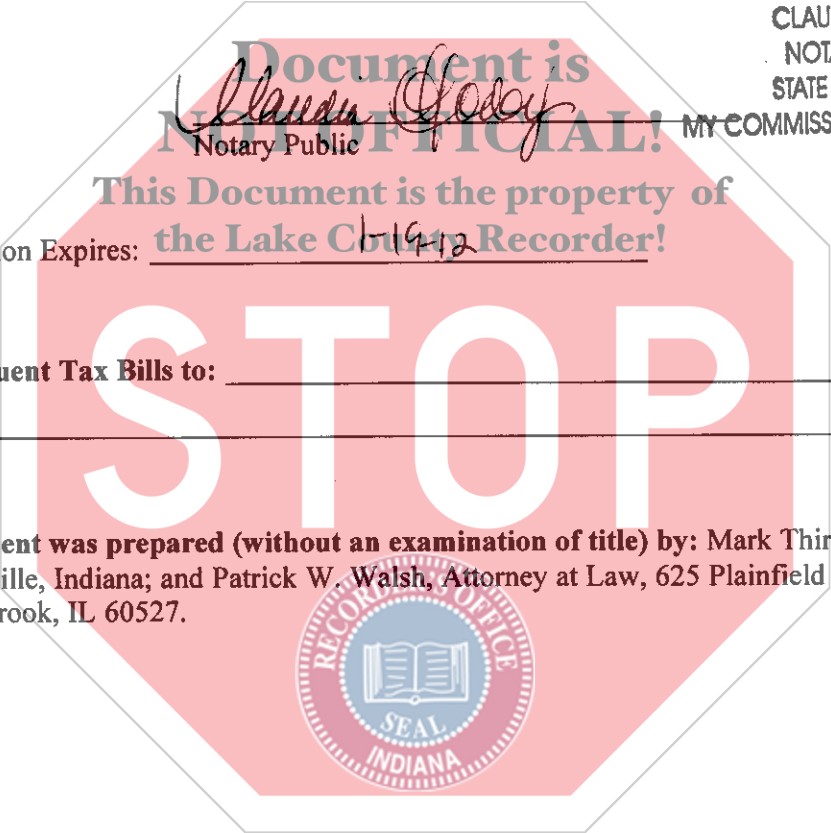
IN WITNESS WHEREOF, CHESTER D. CIESIELSKI executed and caused these presents to be signed as of the day and year first above written.

*Chester D. Ciesielski*  
CHESTER D. CIESIELSKI

State of Indiana                                 )  
  ) ss  
County of Lake                                 )

Subscribed and sworn to before me the day and year above written.

OFFICIAL SEAL  
CLAUDIA GODOY  
NOTARY PUBLIC  
STATE OF INDIANA  
MY COMMISSION EXPIRES 1/19/12



*Claudia Godoy*  
Notary Public

Document is NOT OFFICIAL!  
This Document is the property of the Lake County Recorder!

My Commission Expires: 1-19-12

Send Subsequent Tax Bills to: \_\_\_\_\_

This Instrument was prepared (without an examination of title) by: Mark Thiros, Attorney at Law, Merrillville, Indiana; and Patrick W. Walsh, Attorney at Law, 625 Plainfield Road, Suite 330, Willowbrook, IL 60527.

8ck. CHI 51449

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. 2855-01

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

TYPE/PRINT  
IN  
PERMANENT  
BLACK INK

PRECEDENT

PARENTS

INFORMANT

DISPOSITION

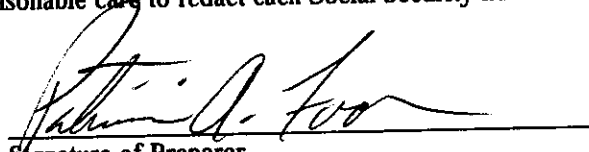
CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) <b>MARCELLA M. CIESIELSKI</b>				2. SEX <b>Female</b>	3a. TIME OF DEATH <b>8:25 A<sub>M</sub></b>	3b. DATE OF DEATH (Month, Day, Yr) <b>November 24, 2004</b>	
4. SOCIAL SECURITY NUMBER <b>311-50-9528</b>	5a. AGE—Last Birthday (Years) <b>57</b>	5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	6. DATE OF BIRTH (Mo, Day, Yr) <b>August, 4, 1947</b>	7. BIRTHPLACE (City and State or Foreign Country) <b>Gary, Indiana</b>		
8a. WAS DECEDENT A U.S. VETERAN? <b>NO</b>	8b. YEAR LAST SERVED IN U.S. ARMED FORCES?	9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <b>XXXX Residence</b>					
9b. FACILITY NAME (If not institution, give street and number) <b>5707 West 122nd Avenue</b>			9c. CITY, TOWN, OR LOCATION OF DEATH <b>Crown Point</b>		9d. COUNTY OF DEATH <b>Lake</b>		
10. MARITAL STATUS (Specify) <b>Married</b>	11. SURVIVING SPOUSE (If wife, give maiden name) <b>Chester D. Ciesielski</b>	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) <b>Homemaker</b>		12b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
13a. RESIDENCE—STATE <b>Indiana</b>	13b. COUNTY <b>Lake</b>	13c. CITY, TOWN, OR LOCATION <b>Crown Point</b>		13d. STREET AND NUMBER <b>5707 West 122nd Avenue</b>			
13e. ZIP CODE <b>46307</b>	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? <b>U.S.A.</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 (0-12) <b>1</b> College (11-4 or 5+) <b>1</b>		
18. FATHER'S NAME (First, Middle, Last) <b>Michael Papusch</b>			19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret M. Kirla</b>				
20a. INFORMANT'S NAME (Type/Print) <b>Chester D. Ciesielski</b>		20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5707 W. 122nd Ave., Crown Point, IN 46307</b>		20c. Relationship <b>Husband</b>			
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) <b>November 26, 2004 Calvary Cemetery</b>		21c. LOCATION—City or Town, State <b>Portage, Indiana</b>			
22a. EMBALMER'S NAME <b>N/A</b>		22b. EMBALMER'S LICENSE NO. <b>N/A</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>1009893</b>		25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME <b>TRUZIN &amp; LITTLE FUNERAL SERVICE #83001261 811 E. Franciscan Dr. Crown Point, IN 46307</b>			
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) <b>a. Acute Pulmonary Edema</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Metastatic Colon CA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>				Approximate Interval Between Onset and Death <b>NOV 29 2004</b>  THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPT			
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>N/A</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> <b>CERTIFYING PHYSICIAN</b> 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"/> <b>HEALTH OFFICER</b> 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"/> <b>CORONER</b> 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> <b>MD</b>				29c. MEDICAL LICENSE NO. <b>IN 043538</b>	29d. DATE SIGNED (Month, Day, Year) <b>11/26/04</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) <b>Dr. Bernardo Lucena 1121 South Indiana Ave. Crown Point, IN 46307 219-663-7000</b>							
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i> <b>But. D.O.</b>				32. DATE FILED (Month, Day, Year) <b>November 29, 2004</b>			
33. MANNER OF DEATH <input 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)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.					

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law.

  
Signature of Preparer

