

CHICAGO TITLE INSURANCE COMPANY

4

Chicago Title Insurance Company

SURVIVORSHIP AFFIDAVIT

620065589

On this 9-20-2006 before me personally appeared _____
(insert date)

GREGORY J. SZYNDROWSKI

2006 088239

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 SON OF OWNER
(state interest of affiant in the above premises as "owner", "son of owner", etc.)

3. Said premises were formerly owned as joint tenants or as tenants by the entireties by GREGORY S. SZYNDROWSKI and MARK S. SZYNDROWSKI
AGNES R. SZYNDROWSKI

4. Said AGNES R. SZYNDROWSKI
(fill in name of co-tenant who died)
died on 12-22-2005
leaving NO will;
(insert "a" or "no"; if will left, attach a copy)

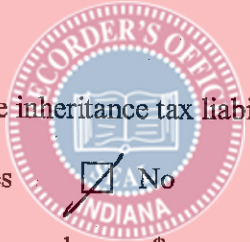
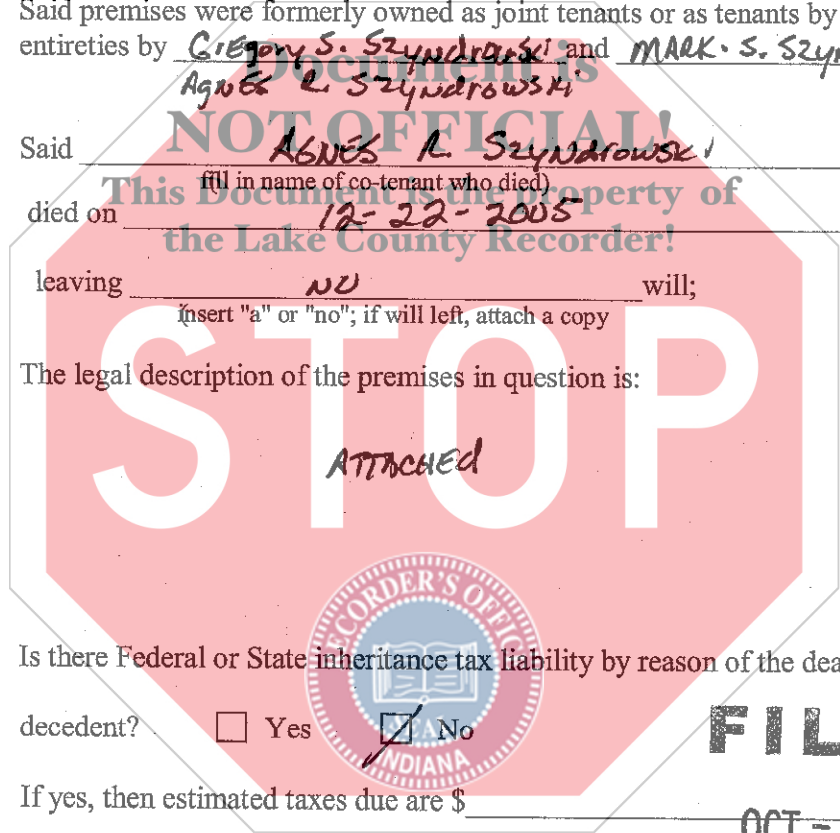
5. The legal description of the premises in question is:

ATTACHED

6. Is there Federal or State inheritance tax liability by reason of the death of said decedent? Yes No

If yes, then estimated taxes due are \$ _____

The taxes due are paid or unpaid..



STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD
2006 OCT 10 AM 9:45
MICHAEL TOWN
RECORDER

FILED

OCT - 6 2006

PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

020341

18-
15
20

7. Where this affidavit relates to a tenancy by the entireties, were the parties ever divorced? N/A

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

N/A):

8. Affiant's relationship to the deceased was SON

Signature: [Handwritten Signature]

Printed Name GREGORY J. SZYNDROWSKI

Address: 9010 SUNRISE LAKE

ORLAND PARK IL 60462

Subscribed and sworn to before me by the affiant

This 9-20-2006
(insert date)

[Handwritten Signature]
Notary Public

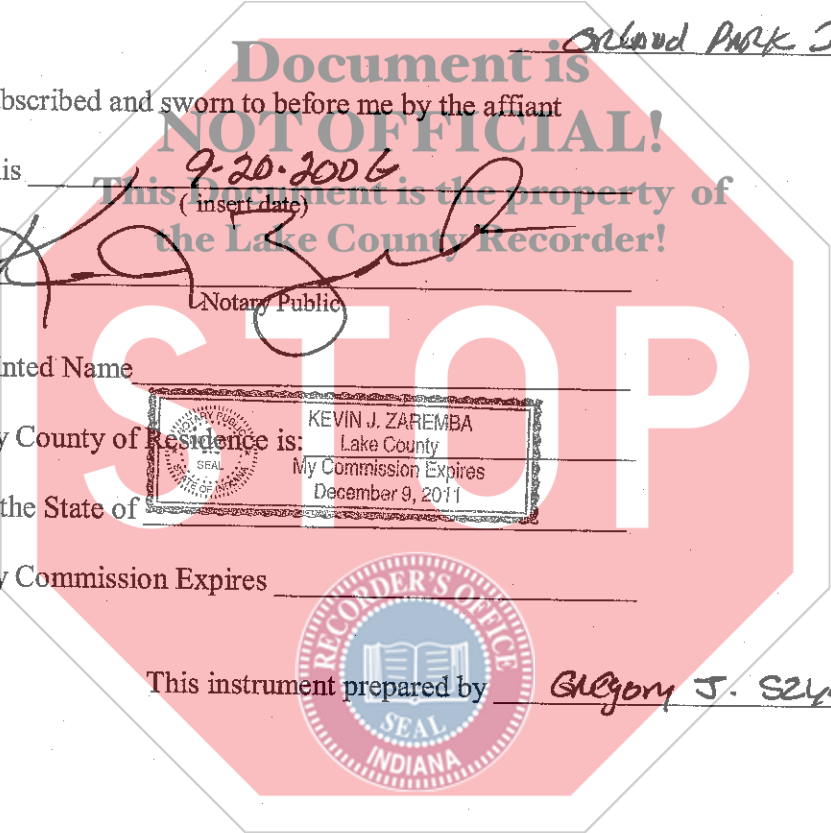
Printed Name _____

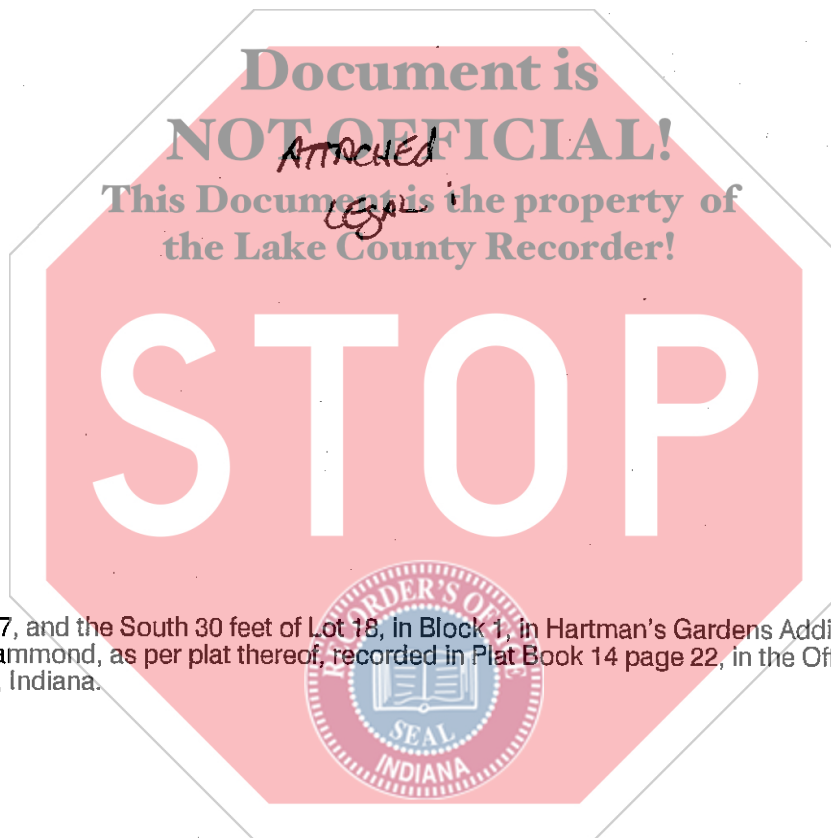
My County of Residence is: KEVIN J. ZAREMBA
Lake County
My Commission Expires December 9, 2011

In the State of _____

My Commission Expires _____

This instrument prepared by GREGORY J. SZYNDROWSKI





The North 10 feet of Lot 17, and the South 30 feet of Lot 18, in Block 1, in Hartman's Gardens Addition to Hessville, in the City of Hammond, as per plat thereof, recorded in Plat Book 14 page 22, in the Office of the Recorder of Lake County, Indiana.

This Commitment is valid only if Schedule B is attached.

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620065589

ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to issue 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. 4240-05
#712050

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

TYPE/PRINT IN PERMANENT BLACK INK

DECEASED

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) AGNES R. SZYNDROWSKI		2. SEX FEMALE	3a. TIME OF DEATH 2:55 A.M.	3b. DATE OF DEATH (Month, Day, Yr) DECEMBER 22, 2005
5a. AGE—Last Birthday (Years) 84		5b. UNDER 1 YEAR Months Days	5c. UNDER 1 DAY Hours Minutes	8. DATE OF BIRTH (Mo, Day, Yr) MARCH 3, 1921
6a. PLACE OF BIRTH (City and State or Foreign Country) EAST CHICAGO, INDIANA		6b. PLACE OF DEATH (Check only one. See instructions) <input checked="" type="checkbox"/> HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9a. FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9b. CITY, TOWN, OR LOCATION OF DEATH MUNSTER	9c. 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) BAKER		12b. KIND OF BUSINESS/INDUSTRY SCHOOL CAFETERIA
13a. RESIDENCE—STATE INDIANA	13b. COUNTY LAKE	13c. CITY, TOWN, OR LOCATION HAMMOND	13d. STREET AND NUMBER 6812 ALABAMA AVENUE	
13e. ZIP CODE 46323	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U.S.A.	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) STEPHEN BADAR		
19. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN BETIK		20a. INFORMANT'S NAME (Type/Print) GREGORY SYNDROWSKI		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9070 SUNRISE LANE, ORLAND PARK, IL 60462		20c. Relationship SON		
21a. METHOD OF DISPOSITION <input checked="" 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) DECEMBER 27, 2005 ST. JOHN - ST. JOSEPH CEMETERY		21c. LOCATION—City or Town, State HAMMOND, INDIANA
22a. EMBALMER'S NAME LARRY D. ANTHONY		22b. EMBALMER'S LICENSE NO. 01001447	23. WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
24a. SIGNATURE OF FUNERAL DIRECTOR <i>Larry D. Anthony</i>		24b. LICENSE NUMBER (of License) 01001447	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME ANTHONY & DZIADOWICZ F.H. #83002916 9445 CALUMET AVE, MUNSTER, IN 46321	
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. IMMEDIATE CAUSE (Final disease or condition resulting in death) Respiratory failure DUE TO (OR AS A CONSEQUENCE OF) metastatic carcinoma to lungs Conditions, if any, which gave rise to the immediate cause, naming the underlying cause last PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I. Coronary Artery Disease, Hypertension Congestive Heart failure		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, at 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>L. Anthony</i>		
29c. MEDICAL LICENSE NO. 01043474A		29d. DATE SIGNED (Month, Day, Year) DECEMBER 23, 2005		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) KANTILAL S. PATEL, M.D. 525-527 W. CHICAGO AVENUE EAST CHICAGO, INDIANA 46312				
31. HEALTH OFFICER'S SIGNATURE <i>Sunder D. Patel, D.O.</i>				31. DATE FILED (Month, Day, Year) December 27, 2005
32. 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)		34e. LOCATION (Street and Number or Rural Route Number, City or Town, State) DEC 27 2005		
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		

