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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 094919

2006 OCT 30 PM 3:06

MICHAEL A. BROWN
RECORDER

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STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

AFFIDAVIT

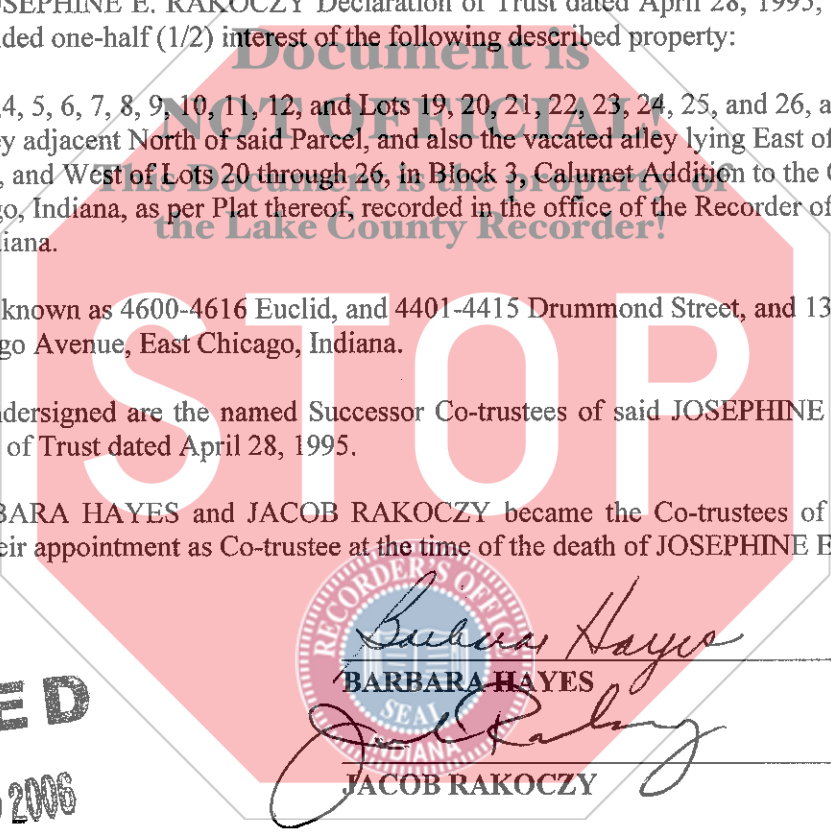
BARBARA HAYES and JACOB RAKOCZY, being first duly sworn upon their oath, depose and say:

1. That **JOSEPHINE E. RAKOCZY** died on **APRIL 27, 2006**, a resident of Lake County, State of Indiana. A certified copy of her death certificate is attached hereto as "Exhibit A."
2. That at the time of her death, **JOSEPHINE E. RAKOCZY** was the Trustee of the **JOSEPHINE E. RAKOCZY** Declaration of Trust dated April 28, 1995.
3. That the **JOSEPHINE E. RAKOCZY** Declaration of Trust dated April 28, 1995, is the owner as to an undivided one-half (1/2) interest of the following described property:

Lots 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and Lots 19, 20, 21, 22, 23, 24, 25, and 26, and the vacated alley adjacent North of said Parcel, and also the vacated alley lying East of Lots 1 through 8, and West of Lots 20 through 26, in Block 3, Calumet Addition to the City of East Chicago, Indiana, as per Plat thereof, recorded in the office of the Recorder of Lake County, Indiana.

Commonly known as 4600-4616 Euclid, and 4401-4415 Drummond Street, and 1302-1308 Chicago Avenue, East Chicago, Indiana.

4. That the undersigned are the named Successor Co-trustees of said **JOSEPHINE E. RAKOCZY** Declaration of Trust dated April 28, 1995.
5. That **BARBARA HAYES** and **JACOB RAKOCZY** became the Co-trustees of said Trust and accepted their appointment as Co-trustee at the time of the death of **JOSEPHINE E. RAKOCZY**.



FILED

OCT 30 2006

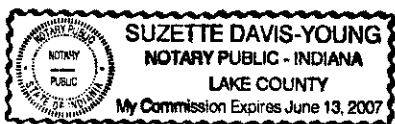
PEGGY HOLINGA KATONA
LAKE COUNTY AUDITOR

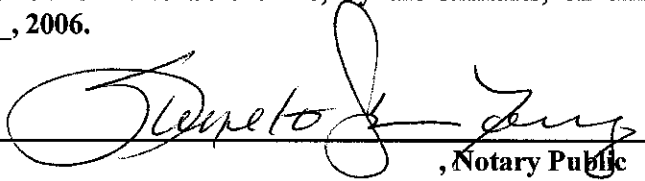
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I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security number in this document, unless required by law. Thomas L. Kirsch.

THIS AFFIDAVIT SUBSCRIBED and SWORN to before me, by the Affiants, on this 27 day of September, 2006.




_____, Notary Public
Resident of LAKE County.

THIS INSTRUMENT PREPARED BY: THOMAS L. KIRSCH, 5224-45, 131 Ridge Road,
Munster, IN 46321, 219-836-1384



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. 1041-06

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

TYPE/PRINT IN PERMANENT BLACK INK

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|------------------------------------|--|--|
| 1 DECEASED—NAME (First, Middle, Last) Josephine Rakoczy | | | | 2 SEX Female | | 3a. TIME OF DEATH 7:50am | | 3b. DATE OF DEATH (Month, Day, Yr.) April 27 2006 | | | |
| 4. *SOCIAL SECURITY NUMBER 306 10 9972 | | 5a. AGE—Last Birthday (Years) 92 | | 5b. UNDER 1 YEAR Months Days | | 5c. UNDER 1 DAY Hours Minutes | | 6. DATE OF BIRTH (Mo, Day, Yr.) Nov 4 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) St Anthony Medical Center | | | | | | 9c. CITY, TOWN, OR LOCATION OF DEATH Crown Point | | | 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) Homemaker | | | | 12b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 13a. RESIDENCE—STATE Indiana | | 13b. COUNTY Lake | | 13c. CITY, TOWN, OR LOCATION Lowell | | | | 13d. STREET AND NUMBER 20000 Calumet Ave | | | |
| 13e. ZIP CODE 46356 | | 13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes 13g. ON A FARM? <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) Anthony Huss | | | | | | 19. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Dziopak | | | | | |
| 20a. INFORMANT'S NAME (Type/Print) Jacob Rakoczy | | | | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20000 Calumet Lowell In 46356 | | | | 20c. Relationship Son | | | |
| 21a. METHOD OF DISPOSITION <input type="checkbox"/> Entombment <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) May 1 2006 St John St Joseph Cemetery Hammond In | | | | 21c. LOCATION—City or Town, State | | | |
| 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 FH83001601 4918 Magoun E Chicago In46312 | | | | | |
| 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. Congestive Heart Failure | | | | | | | | | | Approximate Interval Between Onset and Death one year | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Congestive Heart Failure | | | | | | | | | | | |
| Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last | | | | | | | | | | | |
| 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>[Signature]</i> | | | | | | 29c. MEDICAL LICENSE NO. 01049249 | | 29d. DATE SIGNED (Month, Day, Year) 05/01/06 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) E. Flates 297 W Franciscan Dr Crown Point In 46307 | | | | | | | | | | | |
| 31. HEALTH OFFICER'S SIGNATURE <i>Susan W. Burt, D.O.</i> | | | | | | THIS CERTIFIES THE ABOVE IS A TRUE AND COMPLETE COPY OF THE CERTIFICATE OF DEATH ON FILE WITH THE LAKE COUNTY HEALTH DEPARTMENT. FILED (Month, Day, Year) May 1, 2006 | | | | | |
| 33. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Other | | 34a. DATE OF INJURY (Month, Day, Year) | | 34b. TIME OF INJURY | | 34c. INJURY AT WORK? (Yes or no) | | 34d. DESCRIBE HOW INJURY OCCURRED MAY 01 2006 | | | |
| 34g. DATE PRONOUNCED | | | | | | 34f. LOCATION (Street and Number or Rural Route Number, City or Town, State) EXHIBIT "A" | | | | | |